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Children of Incarcerated Parents

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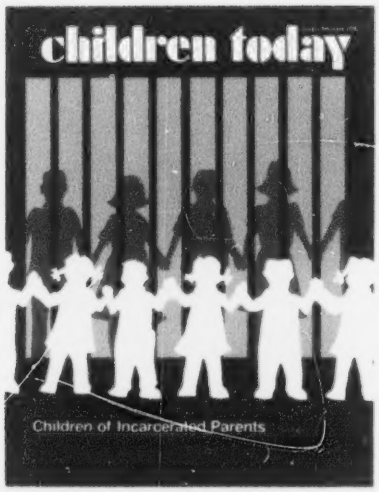

□ What happens to children when their parents are sent to prison?

More often than not, they and their caretakers are left to fend for themselves. As long as children of incarcerated parents "remain hidden in our neighborhoods, classrooms and 'programs,' they receive no support services designed to meet their special needs," authors Louise Rosenkrantz and Virdia Joshua point out in the first article in this issue. Some children are able to cope with this enforced separation—primarily the children of male prisoners, whose fathers may not have been central to their upbringing prior to incarceration. But for the estimated quarter of a million children with a mother in prison, the results of parental incarceration are particularly painful and disruptive.

In their article, the authors examine a number of concerns they have identified in working with inmate mothers and their children at the Prison MATCH/Pleasanton Children's Center at the Federal Correctional Institution, Pleasanton, California—one of four prisons in the United States that house women convicted of federal crimes. Rosenkrantz, director of the Children's Center, and Joshua, inmate coordinator of outreach, also discuss the efforts of the Prison MATCH (Mothers and Their Children) program and Children's Center staff members—inmates as well as "outside" child care professionals—to provide positive visiting experiences, strengthen family ties, enhance parenting skills and assist mothers in resuming parental responsibilites in the community.

Their experiences at Pleasanton, they write, "have also reinforced the need to reach beyond stereotypes and see each parent as an individual. Being convicted of a crime does not mean that a woman is a 'bad' mother any more than living in the community guarantees that she is a 'good' mother. We have found the same range of parenting abilities among inmate parents as among parents in the 'free world' community."

□ "Foster Children Speak Out" (see page 7) allows an often voiceless population to be heard—and the foster children interviewed for the study reported in this article communicate a clear message: a "lack of understanding of their foster care status and reasons for placement," write Eliana Gil and Karen Bogart.

As part of the research study undertaken by the San Francisco Child Abuse Council, the authors asked the children—50 living in foster family homes and 50 in group homes—why they thought they were in foster care. Among their replies:

"Because I was bad."

"My parents didn't want me anymore."

"My mom doesn't have a big enough apartment for me and her."

"Mother ran out on me . . . I think she went to jail."

In addition, several children answered simply, "I don't know."

While well-meaning professionals are often unable to give a child needed information about his or her placement, the authors believe that children deserve to know what decisions are being made regarding their future, and that they should be reassured that they are not in foster care because of their own behavior. Gil, assistant director of the Council's Region IX's Institutional Abuse Project, and Bogart, of the American Institute for Research, urge the "development of a mechanism through which children's thoughts, feelings, concerns and suggestions might be channelled into the system that is created to serve them and their families."

□ "The roughest, toughest youth in the county are meek and malleable during driver education," reports Maryls Schutjer in describing an important incentive for youths enrolled in a day treatment program at the Francis L. O'Brien Center for Youth Development in Ann Arbor, Michigan.

Begun in 1977 as an alternative to residential care for delinquent youth, the day treatment program has resulted in "better services to our teenage clientele, less disruption to their families and a dramatic savings of money," notes the author, who is a consultant to children's agencies in the Michigan Department of Social Services. In her article (see page 20), Schutjer discusses the day treatment philosophy and program and its effects on the young people and their families.

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Children of Incarcerated Parents:

A Hidden Population

by Louise Rosenkrantz and Virdia Joshua

A mother and child are reacquainted at the Children's Center.

Children of incarcerated parents are a hidden population. Unfortunately, as long as they remain hidden in our neighborhoods, classrooms and "programs," they receive no support services designed to meet their special needs.

How many children have a parent in prison? A 1976 study found that of the approximately 25,000 sentenced women imprisoned in the United States each year, about 75 percent have children under age 18.[1] Considering that a mother may have more than one child, and adding the fact that many more women are held in jails without being sentenced, a 1978 review of available data estimated that a quarter of a million children experience the trauma of their mothers' imprisonment each year.[2] No one has even tried to estimate the numbers of children whose fathers are in prison. Since the ratio of imprisoned men to women is close to 20:1, the number of these children must be staggering.

While a massive bureaucracy exists to punish their parents, the children and their caretakers are often left to fend for themselves. According to the most recent statistics published by the Social Security Administration, of the more than 7.8 million families receiving AFDC support in March 1977, about 161,000—2.1 percent—indicated having a father in a correctional institution and only about 9,000—one-tenth of one percent—had a mother in prison.[3]

Very little else is known about these children. Are they in foster care or do they live with relatives? Do their mothers generally resume care after they are released from prison? What are the effects on children of having a parent forcibly removed for indeterminate periods of time? What are the children's special needs? Are there ways to help them cope with some of the difficulties parental incarceration can bring?

A concern about the needs of these children led to the establishment, in 1978, of the Prison MATCH/Pleasanton Children's Center inside the fence of the Federal Correctional Institution in Pleasanton, California, one of four federal prisons that house women convicted of federal crimes in the United States (see box). In the supportive environment of the Children's Center, designed to make the visiting experience a positive one for both parents and children, staff members—inmates as well as "outside" child care professionals—also work to enhance parenting skills as inmates visit with their children or interact with children visiting other inmates.

More than three years and 1,500 child visits later, we still have many unanswered questions. However, our experiences in working with inmate parents and their children have enabled us to identify some significant concerns. Our experiences have also reinforced the need to reach beyond stereotypes and see each parent as an individual. Being convicted of a crime does not mean that a woman is a "bad" mother any more than living in the community guarantees that she is a "good" mother. We have

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Louise Rosenkrantz is Children's Center Director, Federal Correctional Institution, Pleasanton, California. Virdia Joshua is Inmate Coordinator of Outreach.

found the same range of parenting abilities among inmate parents as among parents in the "free world" community.

One of the most significant concerns is, who makes plans for these children and their families? The answers are as diverse as the families themselves: parents, grandparents, other relatives, neighbors, police, courts, social workers—an unending list. Based on their own often painful experiences, many inmate parents are fearful of involving professionals in this crucial decision making and therefore resort to drastic measures to keep plans for their children in their own hands. One mother told us: "I was so scared my kids would be taken from me when I was arrested that I left them with my ex-husband who I knew wouldn't want them. I know it wasn't real good for my kids, but it was O.K. and that way I knew that I'd be sure to have them back when I got out."

With so little help available for planning, it is small wonder that many plans go awry. When Charlotte first came to prison to serve a relatively short (9-month) sentence, her 4-week-old daughter was left in the care of the child's father and his parents, who lived quite a distance from the prison. While this meant that Charlotte would have no regular contact with the infant, the baby would remain in the family setting and no court intervention would be needed.

Six weeks after Charlotte's incarceration, however, a number of changes occurred. The paternal grandmother decided to leave the home and refused to take further responsibility for the child. The child's father decided he did not want the responsibility of a baby. The plans that Charlotte had made for her infant daughter during her 9-month stay had lasted six weeks.

Perhaps if Charlotte had received assistance, the instability of this plan might have been uncovered earlier. Chances are, though, that it would not have been. Plans for children's care even in the most stable situations can be unexpectedly changed. The tragedy is that for most children of incarcerated parents, there is no way for their parents to be involved in implementing new plans. While institution staff may sympathize with the problems, the solution is outside of their jurisdiction and expertise. They are jailers of the parents, not trained children's workers.

For Charlotte, however, there was the Children's Center social service network to call on. The Center's social worker found a foster home near the prison and arranged for the mother to voluntarily place the child there. It is difficult, though, to arrange foster care placements near the prison. Since so many children live outside of Alameda County, the question of who pays for foster care must be resolved—and county foster care homes may simply not be available.

For most parents incarcerated in the United States, a crisis like Charlotte's leads to complete loss of decision making concerning their children's needs. As time goes on, the inmate's loss of involvement in ongoing decision making multiplies, and plans for family reunification become less and less realistic.

Of course, some children do visit their parents in prison, and perhaps these visits can be seen as a source of support for family reunification. We would suggest, however, that in the area of visiting, a lack of real concern around the needs of children has made most prison visiting programs ineffective. One Pleasanton inmate recalled an earlier experience:

"When I was in the county jail, I had my kids visit me so that they could see I was all right. When I'd been busted I was taken away in a hurry and never really got to say

"There are no barred cells or guns within the fence at the Pleasanton institution."

good-bye and tell the kids what was happening. So I had them visit me in the county jail where we had to talk through phones and could not touch each other. We did that just once, so they could see I was okay, but it was really just too hard on all of us."

Even when "contact" visiting is allowed, few institutions provide facilities which are really appropriate for parent/child visits. In the majority of jails and prisons, visiting takes place in crowded, smoke-filled rooms with metal benches and vending machines. Some visiting rooms have tables and chairs. In a scattered number of institutions, there are playrooms where children can go while their parents visit with other adults. And in a few institutions, like Pleasanton, there are parent-child centers which are designed specifically to enhance visiting between incarcerated parents and their children.

Such a variety of conditions means that it is difficult to say with any assurance what a child is likely to experience when visiting an incarcerated parent. Our experiences, however, have enabled us to make some observations about the needs of visiting children.

Obviously, the first concern is whether or not a child should visit a parent in prison—and, unfortunately, this decision is often made by someone who has little knowledge of what the child's visiting experience will be like.

Arimida had been at Pleasanton for four months, separated from her 8-year-old son and 10-year-old daughter, who remained in Texas with relatives, when she learned that the family planned a summer vacation trip to see her. Soon she was told, however, that Eva would not be coming with the rest of the family. The school counselor, whom Eva had begun seeing after the mother's imprisonment, felt that visiting her would be detrimental to Eva's progress.

Arimida was furious since she thought it would be comforting for her daughter to see that she was all right. How, she asked, could the counselor make such an evaluation without knowing the visiting conditions at Pleasanton? The family, after much debate, finally decided to bring Eva with them.

When staff members of the Children's Center first met Eva and her brother, José, they both seemed anxious. On the way to the Center they had many questions to ask: Where were the guns and bars? (There are no barred cells or guns within the fence at the Pleasanton institution.) Are all inmates allowed to wear their own clothes? (Yes) Are the Center staff police? (No, we are a community and inmate staff.) Do I really know their mother? (Yes, she works in the kitchen and helps prepare the food for the Center.) These are, by the way, the questions most commonly asked by school-age children visiting the Center.

"We have seen a tremendous growth of interest in the needs of children of incarcerated parents."

Arimida joined Eva and Jose in the Center, where together they painted pictures. As the children became more relaxed they began to talk with their mother about things going on at home and school. The mother and children put a small jig-saw puzzle together. Then Arimida told the children that she would be going back to the visiting room to talk with other family members and that they could stay in the Center or return with her.

The children decided to stay, and when Arimida had left, new questions came quickly. While Eva sewed and stuffed a small burlap pillow (later to be decorated with her mother's initials), she asked the inmate helping her, Do you know my mother? (Yes.) Is she your friend? (I see her in the kitchen and sometimes we walk on the track together.) Why are you here? (Because this is my punishment for doing something wrong.) Do you have kids? (Yes, three.) Do they visit you a lot? (No, because they are far away in Alaska, but I like being able to spend time and do things with other children like you.) "That's sad," Eva said. "I'm glad I could come."

During the four hours she spent at Pleasanton, Eva walked back and forth between the Center and the visiting room many times—to show the pillow, to show a painting and just to see what was happening. Later, Arimida had lunch with José and Eva in the Center.

The family stayed in the Pleasanton area for a week and visited the prison each visiting day—Thursday, Friday, Saturday and Sunday. Since the Children's Center is open only on weekends, the family spent two of the days in the adult-oriented visiting room.

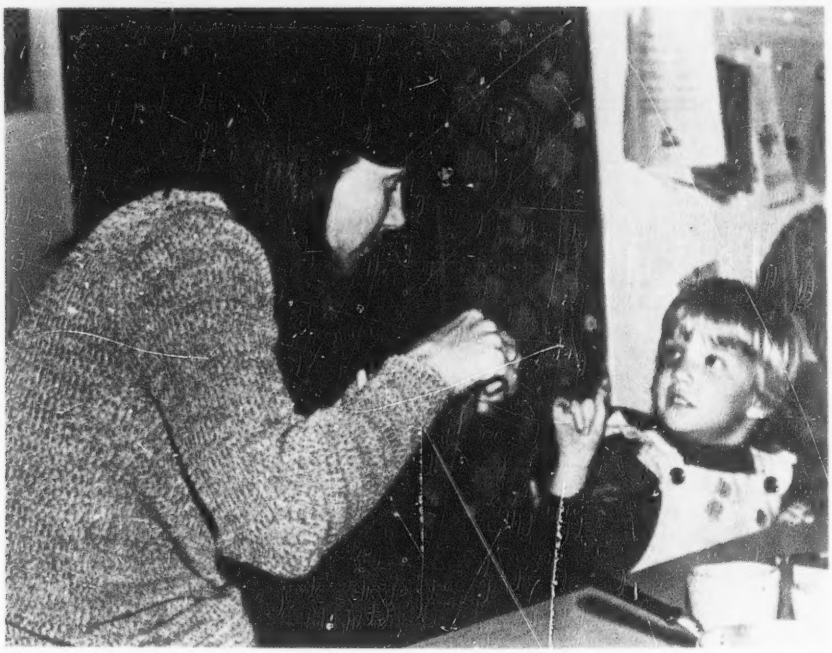
When it was time for the family to return to Texas, there were certainly tears—saying good-bye was difficult, and they did not know when the next visit might occur. But as Eva left with her painting and collages, the Center staff agreed with Arimida's evaluation: "Leaving sure was hard, but I think the visit will give her strength in the long run."

After hearing a presentation about the Pleasanton Children's Center program at a national conference, a warden of a large female institution disagreed about visiting policies for children. She said that if children saw that in some prisons conditions were not as bad as those portrayed on television, they would not be deterred from crime themselves. She argued that some of the children might see prison as a place to receive three square meals a day—something they seldom had.

We view children's relief at finding conditions "not so bad" in a different context. We believe that while the children experience some relief that their parents seem all right, this in no way mitigates their sense of loss at the separation. As one inmate parent put it, "My real prison is not being locked behind bars, my real prison is being separated from my children." For the children, this enforced separation also causes significant pain.

What happens after children kiss their parent good-bye at the Center and return to the community? For some, there is an understanding relative, a concerned teacher or a supportive friend. For others there is just loneliness. Some children are able to cope with this separation (primarily the children of male prisoners, whose fathers may not have been

Photos: Louise Rosenkrantz



Having lunch at the Children's Center.

central to their upbringing prior to incarceration); some children have a much more difficult time. Again, there is no program or agency whose main concern is the child's needs.

Some children of incarcerated parents end up with juvenile records of their own—sometimes as the result of a struggle to maintain family ties. For example, Jeff arrived at the Children's Center to visit his mother after first stowing away on a plane from Wisconsin, ending up in San Diego by mistake, being discovered and taken into custody and spending a month in juvenile hall, where he refused to reveal his identity. Once the purpose of his action was discovered, Jeff spent an additional three weeks in San Diego while county social welfare departments argued about which county would assume the costs of his foster care placement.

A foster home near Pleasanton was found for Jeff. When he arrived, he was a hostile, angry 14-year-old unable to trust anyone. His verbally abusive behavior caused him continual trouble. His initial foster home placement failed, and a subsequent placement in a group home led to expulsion. Finally, there was no place for Jeff to go but to the county juvenile home. After visiting his mother under escort one day, Jeff escaped from the county facility. The last contact his mother had was a short letter saying he'd be waiting at the prison gate on the date of her release. It was postmarked New York City.

An inmate parent's release brings still more changes, particularly where there is a lack of supportive services for children. When an inmate is released to a half-way house, provisions are supposed to be made to assist her in returning to her family and community. Few half-way houses, however, make provisions for children.

When Michelle went to a half-way house after being imprisoned and separated from her 9-year-old son, Stephen, for eight months, her first goal was to return to her role as a stable, dependable mother. During Michelle's incarceration, Stephen had lived with a number of different relatives who had expended considerable effort to keep him in the same school and recreational programs. They had also brought him to the institution to visit regularly, and Michelle had kept in close contact with him through telephone calls and letters. Still, Stephen had developed many disturbing symptoms during his mother's incarceration, including a preoccupation with death and a drastic decline in school achievement.

Luckily, it was possible for Michelle to be placed in a half-way house in the same city as Stephen. But in order to do the things that made Stephen feel as though his life was becoming more normal, Michelle had to leave the half-way house at 5:30 a.m. to be at Stephen's house an hour later. She prepared his breakfast, woke him and spent an hour and a half with him before he left for school. Then Michelle went back to the half-way house for counseling, looked for a job and returned to Stephen's home to be with him after school. She then cleaned house, made dinner, helped Stephen with homework, participated in the good night rituals and hurried back to the half-way house to meet her 11:00 p.m. curfew, while a relative slept back at her home. This schedule lasted six months while the half-way house "helped her adjust to the community."

Once an inmate leaves a half-way house, he or she may still be required to report regularly to a parole officer. Parole officers, like staff members in prisons and half-way

houses, have no jurisdiction over the former inmate's children. While it is hoped that a parole officer will be knowledgeable about community social services for which families are eligible, an ex-inmate might justifiably be reluctant to discuss family difficulties with a parole officer, who has the power to send her back to prison.

After encountering such disturbing examples of the quality of life faced by many children of incarcerated parents, why do staff members of the Pleasanton Children's Center also have feelings of optimism? In the short period of our existence, we have seen a tremendous growth of interest in the needs of children of incarcerated parents. For example, shortly after the Center opened, the Bureau of Prisons adopted a "pregnant-inmate program" designed, developed and lobbied for by a then-pregnant inmate at Pleasanton. This program, which enables inmates (at certain custody levels) to spend the final two months of their pregnancy and the first four months of the newborn's life in a community facility, is now being developed in the federal prison at Alderson, West Virginia. A similar program is planned for two other Bureau of Prison facilities.

Another new development in California is the implementation—albeit slowly—of a bill (A.B. 512) to allow women who have been convicted of certain crimes and who are mothers of young children to serve their sentences in community facilities. However, this program has only served nine women since it began in mid-1980. And at Bedford Hills State Prison in New York, a program to operate a visiting center, nursery and parenting center has recently been funded. Staff members from our program are providing some technical assistance—while, at the same time, receiving good feedback and evaluation of our program.

In 1979 two Prison MATCH inmate staff members and two community media specialists made a videotape, *Prison MATCH: Prison Mothers and Their Children*, to illustrate the issues facing incarcerated mothers.[4] The tape has been shown at numerous conferences and workshops and, as a result, we have had inquiries about the program from interested community groups, educational institutions, prison staff and inmates in many states. In responding to these, we have come to realize that there are many people "out there" concerned about the needs of children of incarcerated parents. The question of how to mobilize ourselves into an effective advocacy group still has to be tackled.

It is this question of effective advocacy which faces us now. As community social services are being cut back, we are faced with the responsibility of alerting the community to still additional social service needs. We must accept this responsibility and commit ourselves to work with other interested groups to identify community needs and continue, despite cutbacks, to press for needed services. Without this kind of united pressure, there will be no significant changes in the lonely plight of children of incarcerated parents. ■

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[1] Ruth Glick and Virginia Neto, *National Study of Women's Correctional Programs*, Sacramento, California Department of Corrections, 1976.

[2] Brenda G. McGowan and Karen L. Blumenthal, *Why Punish the Children?*, Hackensack, National Council on Crime and Delinquency, 1978.

[3] *Recipient Characteristics Study* (Pub. No. SSA 13-11729), Washington, D.C., Office of Research and Statistics, Social Security Administration, Sept. 1980.

[4] For information on the availability of this 18-minute, award-winning, black and white videotape, contact Carla Lowenberg, NCCD/Prison MATCH, 760 Market St., Rm. 433, San Francisco, Calif. 94102.

Prison MATCH

In addition to the Federal Correctional Institution in Pleasanton, California, prisons for women convicted of federal crimes are located in Alderson, W. Va., Fort Worth, Tex. and Lexington, Ky. The woman's crime may range from bank robbery to embezzlement to fraud; it may be of a non-violent nature; and it may be against a person or property. Regardless of where her family may live, a woman convicted of a federal crime can expect to be sent to one of the four institutions.

The Prison MATCH (Mothers and Their Children) program at Pleasanton, a project of the National Council on Crime and Delinquency, is an attempt to strengthen family ties that all too frequently deteriorate during a mother's incarceration, and to provide parenting experiences to assist the inmate in resuming parental responsibilities in the community.

Through an educational component, Prison MATCH offers classes in child development, group discussions on childrearing and opportunities to interact with children visiting the Children's Center. And while enhancing their own parenting skills, inmates can work toward a Child Development Associate (CDA) credential. The CDA program, initiated by the Office of Child Development (now ACYF), awards the nationally recognized credential to child care workers who have demonstrated competence in working with young children.

Through a social services component, Prison MATCH's part-time social worker and inmate coordinator arrange foster care placements for children when possible, usually on an emergency basis, in Alameda County foster homes. In addition, they are available for consultation with inmates and institution staff on problems concerning inmates' children.

Inmates are involved in planning and conducting Prison MATCH programs and serve on the administrative board.

Prison MATCH has been funded by the Rosenberg and the San Francisco foundations, as well as by several smaller foundation grants. The Bureau of Prisons also contributes substantially to the funding of the Children's Center.

Additional information about Prison MATCH may be obtained from Carla Lowenberg, National Council on Crime and Delinquency, 760 Market St., Rm. 433, San Francisco, Calif. 94102. ■

Foster Children Speak Out:

A Study of Children's Perceptions of Foster Care

by Eliana Gil and Karen Bogart

For more than 50 years, researchers have studied the impact of foster care placement on children. Rarely, however, are foster children asked about their feelings and reactions, nor do they have a consistent mechanism for providing input into the system designed for their care.

The purpose of the small research study described here, undertaken by the San Francisco Child Abuse Council, was to allow foster children the opportunity to express their perceptions about the quality of care they receive, why they think they are in foster care, what they expect the future holds for them, and how they think the system could be improved for other children.

For the study, 100 foster children—50 living in foster family homes and 50 in group homes—were interviewed. Ranging in age from eight to 18, the children came from diverse ethnic backgrounds including, in addition to white, black, Hispanic and Asian children, eight who classified themselves as "other." Many children appeared hesitant as to ethnic identity, not always because they were of interracial backgrounds but because the foster parents occasionally were from different ethnic groups than their biological parents.

The children were randomly selected from a computer printout list, provided by the San Francisco Department of Social Services, of all children in placement in June 1979. The chief of the Department's Division of Family and Children's Services wrote to the children's foster or group home parents explaining the purpose of the study and encouraging their cooperation.

Child Abuse Council staff recruited and trained a small group of volunteers to administer questionnaires to the children; staff members also administered many of the questionnaires themselves. Volunteers called foster parents to schedule a convenient time to interview the children and, with older children, scheduled times directly with them.

When they arrived at the homes, the volunteers discussed the study with foster children and parents, stating simply that it was being conducted by the Department of Social Services to give foster children an opportunity to tell what it was like for them to be foster children. (A decision was made by Child Abuse Council staff *not* to tell the children of the Council's involvement, so the responses would not be baised.) The volunteers emphasized to the children that the questionnaires were confidential, that they need not sign their names to them, and that they would not be read by anyone except those analyzing the data.

"My parents didn't want me anymore."

Instructions for filling out each section of the questionnaire were provided, and foster parents who wanted to "help" the children were gently escorted out of the room. The volunteers assured the children that they would be available if help were needed in understanding any of the words or questions.

To make sure that the children's reading level would permit comprehension, the volunteer asked them to read and fill out the first two items of each section. More often than not, the volunteers had to read the entire questionnaire to the children because many were unable to read or comprehend the instructions. The volunteers were asked to spend some time socially with the children to ascertain whether they were emotionally upset about responding to the questions, and foster and group home parents were also requested to be available to the children after they completed the questionnaires in case they wanted to talk about personal matters raised in the process.

Volunteers reported that most of the children seemed to enjoy filling out the questionnaires and talking with them. In some instances, the children showed the volunteers their rooms or toys and seemed delighted to have someone visit them.

The Questionnaire

Two questionnaires were developed, one for the 8- to 12-year-old group and one for the 13- to 18-year-olds. The only difference was in language complexity.

The four sections of the questionnaire included:

- The Coopersmith Self-Esteem Test, which asked children whether they agreed or disagreed with a number of declarative statements ("I'm a lot of fun to be with," for example) designed to measure self-esteem.
- The Parks Career Role Inventory, which first asked children to choose from a list of professions which job they would like to have and then to imagine that they had grown up and to indicate what they thought they would be doing.
- A Behavior Checklist, an original

Eliana Gil is Assistant Director, Region IX's Institutional Abuse Project, San Francisco Child Abuse Council. Karen Bogart, Ph.D., is associated with the American Institute for Research, Palo Alto, Calif., and Washington, D.C.

design consisting of multiple choice questions and statements addressing such topics as diet, activities, interpersonal relationships, personal possessions and future aspirations.

• Four open-ended questions designed to elicit the children's perception of foster care: "The best place I ever lived was..."; "This was because..."; "Is there something you would recommend that could make things better for children and teenagers in foster care?"; and "Why are you now in foster placement?"

Results

While all of the foster children scored somewhat lower than the standardized norm in self-esteem, children in foster family homes had slightly higher self-esteem than children in group homes. On the Parks Career Role Inventory, both boys and girls tended to select low-status, sex-stereotyped occupations—boys chose truckdriving, for example, and girls, hairdressing. Seventeen percent showed a disparaging difference between their career wish (for example, doctor) and what they perceived as future reality.

"Just pretend that your foster parents are your real parents, and everything will come out fine."

On the Behavior Checklist children in foster family homes reported a more varied diet, more opportunities for interpersonal relationships with friends, more positive family relationships, and more personal belongings and privacy. Eighty percent of the children in foster family care reported feeling safe and secure as compared with only 47 percent of the children in group care: 56 percent of the children in foster family homes, and 42 percent of group home children, reported frequent punishment; and 76 percent of the foster family children reported living in the same home for three years or more, as compared with only 42 percent of the children in group care. While the intent of the study was not to compare children in the two settings (an impossibility), the differences are of interest.

In responding to the open-ended question about the best place they had ever lived, 81 percent of the children in foster family homes reported liking their current placement, while only 47 percent of group home children liked their arrangement. Fifteen percent of foster home children, and 39 percent of group home children, felt that their natural home (with parents or relatives) was the best place to live.

Why was a particular place considered the "best"? Children in foster family homes explained: "They [the family] are the only ones I've ever lived with and I love them"; "I have fun here all the time" and "We go lots of places"; "They treat me like any person would want to be treated"; and "I feel safe and I love them."

In answering the same question, children in group homes had this to say:

"They let me do my own thing, and make most of my own decisions."

"Because it's the only place that I didn't want to leave."

"It was a home setting with houseparents that never went off duty."

"They help me in a lot of areas I need help in."

"There is a lot of love and warmth in that group home."

The children had specific recommendations for improving foster care. Children in foster family homes suggested that foster parents play games with foster children, give love and affection and allow foster children more freedom to make their own choices. One child offered this advice to other foster children: "Just pretend that your foster parents are your real parents, and everything will come out fine."

More homes, more staff and more money for programs were among the recommendations of group home children. "Let them [the children] pick their own social worker" and "the place where they feel comfortable," they suggested, and several emphasized the importance of having someone to listen to them.

To the last question, asking why the children thought they were in foster care, children in foster family homes answered:

"I had problems at home."

"My mother can't afford me."

"My parents didn't want me anymore."

"My mom doesn't have a big enough apartment for me and her."

"Because I was bad."

"Because my mother and father died... then my grandmother died too."

"Mother ran out on me... I think she went to jail."

The answers of children in group care included the following:

"I have no family or anywhere else to live."

"Because my real parents put me up for adoption."

"My parents have now decided that they don't want me anymore."

"Because of the trouble I used to get into."

"Because I need to solve a few family problems."

"Because me and my mother don't get along and I'm on probation."

"Because my mom can't handle me and she's an alcoholic.

In addition, several children in both groups answered simply, "I don't know."

Discussion

It is important to emphasize that this was a small-scale, exploratory study and that no control group of children was available. Although attempts were made to obtain a control group of children in public schools, problems in such areas as the need for parental consent forms and the school district's policy regarding the testing of children made the process too time-consuming and complicated.

Moreover, as with any self-reports, there is the possibility that some children did not report accurately, either because they chose not to or found the material emotionally upsetting.

"... children need help in understanding the events that led to placement and in coming to terms with their current situation."

It is important to note that while certain differences were observed between foster family and group home children, it is not possible to determine whether these differences are caused by the experience of one type of care or another or whether, in

fact, prior differences in the children caused their placement in a particular type of care. We found some indication that age and sex may affect decisions regarding the type of placement to which a child is assigned—in this study, children in group homes were older (15.2 years compared with 11.8 years for children in foster family care) and a majority of the boy (32 versus 21) lived in group homes while most of the girls (29 versus 18) lived in foster family homes.

Our interpretations, however, have emphasized patterns rather than significance of individual items—and the patterns reveal a consistent difference, with children in foster family homes scoring higher than group home children in self-esteem and on those variables (family relationships, safety and security, personal belongings and privacy, for example) associated with higher self-esteem.

". . . children deserve to know what decisions are being made, or have been made, regarding their future."

Some reasons for this might be the differences in the ages of children in foster care and group care, or the fact that it is often children with problem behavior, or a history of family conflict or school disturbance, that are seen as more likely candidates for group homes. In addition, group homes are traditionally used if the child has "failed" in foster family home settings or requires counseling services.

The study findings highlighted two areas that are of primary concern to staff members of the Child Abuse Council. The first points to the educational needs of the foster children. Many of the children interviewed could not read the questionnaire with comprehension or write responses. Volunteers frequently had to read the questions, even to older children, and not one child who answered the open-ended questions wrote a grammatically correct sentence. (Since there was no comparison group, it is difficult to say whether this apparent deficit in educational skills is unique to children in placement.)

Many of the foster parents reported their frustration at being unable to obtain the specialized care and tutorial services they felt the children needed; some indicated that the children had been on waiting lists to receive services "for a long time."

We believe that this area requires attention from placement workers, social workers or others who conduct initial assessments, as well as by school personnel serving children in placement. It may well be that some of these children have undiagnosed developmental or emotional disabilities, and early screening could result in improved planning and services for them. For foster children, who frequently have low self-esteem, this is particularly crucial since success in school could have a positive impact on their self-image.

The second area, the children's lack of understanding of their foster care status and reasons for placement, is of particular concern.

We are convinced, as Charles Horejsi has emphasized, that children need help in understanding the events that led to placement and in coming to terms with their current situation.[1] A child also should be helped to develop a relationship with at least one other person who really cares about him or her and can affirm the child's self-worth.[2]

If all efforts are made to prevent placement, and if efforts fail, there is little we can do to avert all separation pain to the child and family. However, there is a great deal we can do to minimize the trauma of separation and assist the child in developing a sense of self-worth.

We believe that children should be reassured that they are not in foster care because of their behavior,[3] and that the reason for placement must be explained so that they can begin to disown some of the guilt and suffering that is frequently present in foster children.

We also believe that children deserve to know what decisions are being made, or have been made, regarding their future. One child in the study, for example, had been relinquished for adoption and his foster parent had almost completed the formal adoption procedures. When asked why he was in placement, however, he replied, "because my mother can't find a big enough apartment. . . when she does, she'll pick me up."

This child was not told about his current status because the foster parent and worker did not want him to become upset. The impact of withholding information may be equally damaging in the long run, however, since a child may continue to nurture a fantasy and not have the opportunity to grieve and separate when appropriate.

Well-meaning professionals are often unable to give a child needed information about his or her placement, either because the workers do not know and cannot project what course the future will take, or because of a sense of protectiveness towards the child. Many workers want to prevent an emotional upset and, unfortunately, keep children in a state of limbo where they are unable to resolve some of the pain, work through the grieving process and begin to form trusting attachments with others. These good intentions frequently compound the problems the child must eventually face.

"There is a great deal we can do to minimize the trauma of separation and assist the child in developing a sense of self-worth."

While the data yielded by this small study may not be unexpected or extremely revealing to those in the child welfare field, we believe that the findings have implications for the foster care system.

We urge the development of a mechanism through which children's thoughts, feelings, concerns and suggestions might be channelled into the system that is created to serve them and their families. Ways should also be sought to improve service delivery so that the trauma of removal and placement is minimized. ■

[1] Charles Horejsi, *Foster Family Care: A Handbook for Social Workers, Allied Professionals and Concerned Citizens*, Springfield, Ill., Charles C Thomas, 1979.

[2] Ibid.

[3] According to the article, "Foster Care in California" (*Public Welfare*, Nov. 1977), only 20 percent of the total number of children in custody of all California agencies are in placement because of their own behavior or disability.

Discipline in the 1980s:

Some Alternatives to Corporal Punishment

by Irwin A. Hyman and Dolores Lally

Most Americans believe that hitting is a perfectly appropriate and often necessary disciplinary method in order to change children's behavior. In the schools, suspension is frequently used as a disciplinary procedure. These approaches to discipline are even more pervasive in the growing private school movement. Public school children have rudimentary constitutional protection in suspension cases, although they have none regarding corporal punishment. However, in private schools, children have little or no protection, an especially crucial factor since the number of private schools is increasing.

We at the National Center for the Study of Corporal Punishment and Alternatives in the Schools, Temple University, are attempting to convince the public that hitting is an unnecessary and ineffective form of discipline—one that may lead to unintended consequences for children. The elimination of physical punishment of children, we believe, could lead to the elimination of most child abuse cases.

We are currently working to inform the public about what is happening in the schools and to help educators, parents and institutional personnel develop repertoires of alternative, positive approaches to discipline. One of the ways in which we do this is through information gathering—by documenting examples of corporal punishment and gathering statistical data on it. For example, our files, based on newspaper clippings, articles and letters from the public, show that students in American schools have been subjected to the use of the paddle, strap, hand, arrow, stick, rope, belt and fist. In addition, students have been subjected to having hair cut off; they have been placed in storerooms, boxes, cloakrooms, closets and school vaults; they have been thrown against walls, desks and concrete pillars; and they have been forced to run the "gauntlet" or "belt line." Other forced punishments include making a child perform military style push-ups; sticking a pin in a child; taping a child's mouth, hands or body; undressing a child in private or before peers; making a child stand on toes for long periods of time; punching, choking or dragging a child by the arm or hair; withholding meals; forcing a child to stand in pajamas in 20-degree weather, to lay on a wet shower floor in clothing, or to eat cigarettes; tying a child to a chair—all documented examples of child abuse perpetrated by school staff members under color of school law.

The cases mentioned here represent the tip of the iceberg since they were culled mainly from newspaper clippings. Other statistical data, especially that obtained from the Office of Civil Rights Surveys of Education, indicate massive use of corporal punishment and suspensions on children of minority groups.

Center Workshops

Of practical significance are the variety of workshops the Center provides, all tailored to individual and institutional needs. One major workshop, "Seven Approaches to Discipline," is based on research performed by the Center under contract to the National Institute of Education and is designed to help participants gain a broad perspective on theory and practice in the area of discipline.

During the first segment of the all-day workshop, the major theories of human behavior—psychodynamic-interpersonal, behavioral, human potential, ecological, sociological and biophysical—are outlined and discussed. An eclectic process approach is used to align and integrate complementary components of the six major theoretical orientations.[1]

After these theoretical explanations for behavior and misbehavior are introduced, participants learn problem-solving strategies to diagnose and remediate discipline situations within each conceptual framework. Throughout the program, the techniques suggested for each approach are compared and contrasted so that participants will be able to judge the appropriateness of a variety of interventions for any situation in which discipline is warranted.

Participants view videotapes portraying a spectrum of school discipline situations and then break up into small discussion groups to explore a common problem situation from each of the six theoretical perspectives. After the small groups diagnose the specific components of the case, a list of possible intervention strategies is developed. The participants then reconvene to report, contrast and evaluate the conclusions of each theoretical analysis.

For instance, in a situation in which a child is too noisy, behaviorists would suggest ignoring the noisy behavior and reinforcing positive behavior; those employing the

Irwin A. Hyman, Ed.D., is Director, National Center for the Study of Corporal Punishment and Alternatives in the Schools, Temple University, Philadelphia, Pa. Dolores Lally is a doctoral candidate in school psychology at Temple University.

[1] I. Hyman and D. Lally, "Effectiveness of Staff Development Programs to Improve School Discipline," paper presented at the annual convention of the American Psychological Association, Montreal, Canada, September 1980.

ecological approach would seek to stop the behavior immediately; and advocates of the human potential view would specify that the child be allowed to discuss what being noisy means to him or her and the other children.

After viewing a segment that portrays a senior high school girl becoming agitated and verbally aggressive with her teacher, the group examining the psychodynamic-interpersonal approach might recommend family counseling to help the student resolve her problems in dealing with authority figures. Behaviorists might suggest a specific behavioral contract between the student and teacher listing expectations and contingent consequences. The ecological group may conclude that the curriculum is not meeting the student's academic needs. The biophysical group might raise the issue of a possible drug dependence problem. The human potential group might suggest a class meeting to discuss classroom rules and the roles of students and teachers in an educational system. The sociological group could discuss community norms for teenage behavior and the value of education.

The following example illustrates how some of these approaches might be applied to a very severe discipline problem.

Mrs. Jones, a kindergarten teacher, had been having great difficulty with Johnny, a 5-year-old who was extremely active in class, always grabbing other children's things. Johnny, who seemed in general to be immature for his age, was also prone to hit other children and he had had several temper tantrums. When Mrs. Jones tried to control him, he struck her.

Using a psychodynamic-interpersonal approach to handling the problem of disciplining Johnny, a teacher might hypothesize that some problem related to Johnny's home life was the cause of his difficulties. Consistent with this approach, the teacher would spend time interviewing the parents in an attempt to discover what developmental stages were being disrupted—and why. In this kind of situation the teacher might discover, for instance, that Johnny's mother had recently remarried and so his developing relationship with his biological father had been interrupted, at a time when male role identification was important to his development. The stepfather may have been seen by the child both as a competitor for his mother's attention and as one who was displacing his real father, with whom he wished to be. If so, Johnny might be acting out his aggression and frustration as a result of his inability to complete a normal developmental stage of identification with his father.

Using a behavioral approach, the teacher might assume that Johnny's negative aggressive behavior was also being reinforced in some way. She might observe the instances and tally the number of times he exhibited such a specific behavior as hitting, and then begin to analyze why and how it was being reinforced. Concurrently, she might begin to reinforce his positive behaviors and to offer rewards for short periods of time when he didn't hit other children. She might also set up a similar schedule for the parents at home, so that he would begin to get more and more reinforcement for his non-aggressive behavior.

From an ecological point of view, the teacher might analyze which classroom situations seemed to promote Johnny's aggressive behavior. She might then discover that she let the situation get out of hand when the children had free play time. As a result, she might rearrange his schedule and have an aide spend more time with him during the free play period. She would also learn to anticipate Johnny's outbursts and to move him out of a situation as soon as it looked like a confrontation was about to occur. She might begin remediative processes by teaching the whole class how to negotiate the use of toys on a shared time basis.

With the biophysical approach, the teacher would want to investigate what physical causes might be associated with Johnny's hyperactive behavior. A thorough medical and psychological evaluation could be undertaken to help determine whether his acting out had a medical basis. It might be found that certain medications were necessary to help him gain control of his behavior. Or, it might be found that his sleeping or eating habits were responsible for his irritability.

From a human potential approach, the teacher might try to understand what was frustrating Johnny and keeping him from meeting some of his needs for love, affection, safety and accomplishment. She might find that the routine of the class was too structured for him. He might be a very bright child who was extremely frustrated in his inability to do the kinds of things which he might want to do. She might find that his activities were preventing him from achieving certain accomplishments and that a vicious cycle, in which Johnny would function as if he truly were a bad child, was occurring.

As a result, the teacher would attempt to provide an atmosphere in which Johnny could learn to appropriately act out his frustration and aggressions. When he became angry, an opportunity could be provided for him to vent his feelings on an inflatable punching bag instead of hitting other children. The teacher might also provide him with artistic means for expressing his frustration and anger, play therapy might be utilized and parents might be

recruited to help Johnny develop a more positive self-image by decreasing the kinds of negative statements made to him about his behavior.

As indicated by Johnny's example, application of a variety of theoretical orientations can result in a number of practical solutions to a single behavioral problem. The purpose of the Center's training activities is to help educators generate a vast repertoire of theoretical and practical solutions to discipline problems. Most teachers do not appear to have a consistent approach to discipline based on theoretical assumptions; this workshop helps teachers to identify their own orientation and to contrast it with others. And, to help reinforce the training received in the workshop, the center makes tapes and other materials available for use by schools.

Another workshop is on physical restraint. Most teachers have had to deal with students' uncontrollable behavior and it is important for them to understand the legal, pedagogical, psychological and physical parameters involved in physical restraint.

The workshop emphasizes that in utilizing physical restraint teachers should analyze the situation vis-a-vis the child's background and his or her current state of mind. Environmental restrictions and dangers must be considered, and vocal control should always be tried first. If physical restraint is necessary, after all prevention measures have been eliminated, the teacher should move himself or herself behind the child and out of the way of possible attack. A procedure for placing the child in a "basket hold" or "wrap up" is demonstrated in the workshop.

This method of physical restraint may be necessary and can be effective when the teacher is physically able to control the child. But if a teacher is smaller than the student or not as strong, it is inadvisable for him or her to physically engage the child. Other practices, however, can be employed to help reduce the possibility of violence occurring—and the Center urges that schools, especially ones in which there are older, potentially more aggressive children, develop procedures which anticipate this possibility. (In a recent research study conducted by the Center in the Philadelphia schools, junior high school teachers indicated a high priority for establishing set procedures for dealing with aggression against teachers in the classroom.) For example, we point out the importance of making certain that the school intercom system always works properly so that a teacher can get help quickly. We also suggest that teachers who are physically small or unable to handle larger, aggressive children always be assigned classrooms that are near other teachers who could be helpful in such a situation. In our workshop, teachers learn methods of identifying and verbally handling children when they appear to be moving toward an outburst and they receive appropriate training to help them avoid needlessly antagonizing students and precipitating violent episodes.

Other Center workshops include approaches to stress management for teachers and the measurement and adjustment of classroom climate in preventing severe disciplinary problems.

Center Research

One Center study of processes common to various inservice teacher training programs has been of great importance in developing workshops and generating further research. The first stage of the study was a comprehensive review of research on the effectiveness of such popular teacher training programs as Teacher Effectiveness Training, Behavior Modification and Classroom Ecology. Twenty-seven programs were examined and common practices identified and sorted into seven teaching process categories.

The study showed that teachers used verbal methods most frequently to show students that their ideas and feelings were recognized and accepted as valid forms of self-expression. Here, a teacher might say: "John, I realize that you are angry with the group for not letting you play in the kickball game at recess. You must feel as though you have no friends here." Also included in this category are statements of objective verbal feedback in regard to students' positive behavior: "Jean, I noticed that you tried very hard to control your temper when Jill stepped in front of you in line. That is a real improvement."

The second most common classification of the teacher processes considered relates to their gathering of objective diagnostic information about students' feelings and behaviors. Also included in this category is the influence of a teacher's beliefs and characteristic behaviors on classroom interaction. For example, when Ms. Scott was discussing with her students their responses to a questionnaire about their math lessons, she discovered that her apparent dislike of the subject had influenced the entire period. In other words, many of the in-service programs urged teachers to gather information on classroom behavior so that they might obtain objective feedback about what was happening.

Classroom ecology, including the physical arrangement of the room, the structure of class activities and decision-making policy, was found to be a common concern. For example, a teacher could decide that Tim and Martha should not work at the same learning center after lunch, because sitting together made it hard for them to concentrate and return to work, a factor the teacher might not have recognized before she, Tim and Martha had discussed what situations might be causing behavior problems.

Because occasional student misbehavior is inevitable, many of the training programs examined included methods of dealing with inappropriate behaviors. However, it was interesting to note that the majority of these programs strongly emphasized the use of reward and encouragement to prompt cooperative behavior, rather than punitive techniques to decrease disruptive behavior. (A

teacher would attempt to "catch" a student engaged in an appropriate task and then verbally praise him for his cooperation.)

Several training programs encouraged specific instruction and practice in devising and using problem-solving strategies in attempts to insure student cooperation and participation. Some of these programs suggested direct involvement of students in classroom policy negotiations—for example, Mr. Johnson would hold a class meeting in which the students would determine the work requirements that had to be met each morning to earn extra privileges.

Recognition of teachers' feelings in the classroom was considered an important factor in cooperative student-teacher relationships. Several programs encouraged teachers to share their relevant feelings with their students: "Tom and Bob, I get angry when you talk to your friends while I'm trying to teach a new lesson."

The expression of student feelings is equally important. Peers and teachers often fail to realize the impact a careless comment can have. Structured group activities may help students express their own feelings and to understand how others may feel. The use of a "magic circle," which is classified within the human potential approach, is one popular affective technique.

Other Center research activities focus on the causes of teachers' use of corporal punishment, the relationships between corporal punishment, suspension and vandalism and school disciplinary codes.

We believe that together the Center workshops, advocacy, research and information programs represent a unique effort on the part of parents and professionals to stem and turn back the current tide of punitiveness towards children. ■

The National Center for the Study of Corporal Punishment and Alternatives in the Schools

by Irwin A. Hyman and Dolores Lally

In 1972, a group of citizens, including educators, writers, lawyers, parents and psychologists, formed the National Committee to Abolish Corporal Punishment in the Schools. Several of the Committee's leaders had sought to establish a university-based center that could launch an effective program to educate the public about good and bad forms of discipline. In conjunction with the American Psychological Association's Task Force on the Rights of Children and Youth—and other national organizations, such as the American Civil Liberties Union—the Committee helped to establish the National Center for the Study of Corporal Punishment and Alternatives in the Schools in 1976.

The original purpose of the Center, which is located on the campus of Temple University within the Department of School Psychology, was to focus exclusively on research, dissemination, education and advocacy. These goals are still pursued as major Center functions, along with the activities described in the accompanying article.

Financial support for the Center comes from such diverse sources as The Randen Foundation, The Playboy Foundation, The Faulk Medical Fund and The Fels Fund, as well as from Center members. The College of Education at Temple University and the Department of School Psychology offer in-kind services, including space, phone service, graduate assistantships and released professorial time, all of which have enabled the Center to establish itself as a permanent organization with a substantive service record.

The expertise of Center staff members concerning corporal punishment, suspensions and other punitive techniques is often tapped in litigation. Preparation of affidavits and provision of social service data and expert testimony are among the services offered. Staff members have worked with the Center for Law and Education in Cambridge, Mass., the American Civil Liberties Union and many local legal advocacy groups. In addition, staff members have aided individual lawyers and testified before state legislative committees.

Those interested in obtaining additional information on Center materials, workshops, services and research activities, or in joining the Center, should write to the National Center for the Study of Corporal Punishment and Alternatives in the Schools, 833 Ritter Annex, Temple University, Philadelphia, Pa. 19122. ■

Chicago's Fountain Of Discovery

Education Programs at the Museum of Science and Industry

by Victor J. Danilov

Photos: Courtesy of Chicago's Museum of Science and Industry

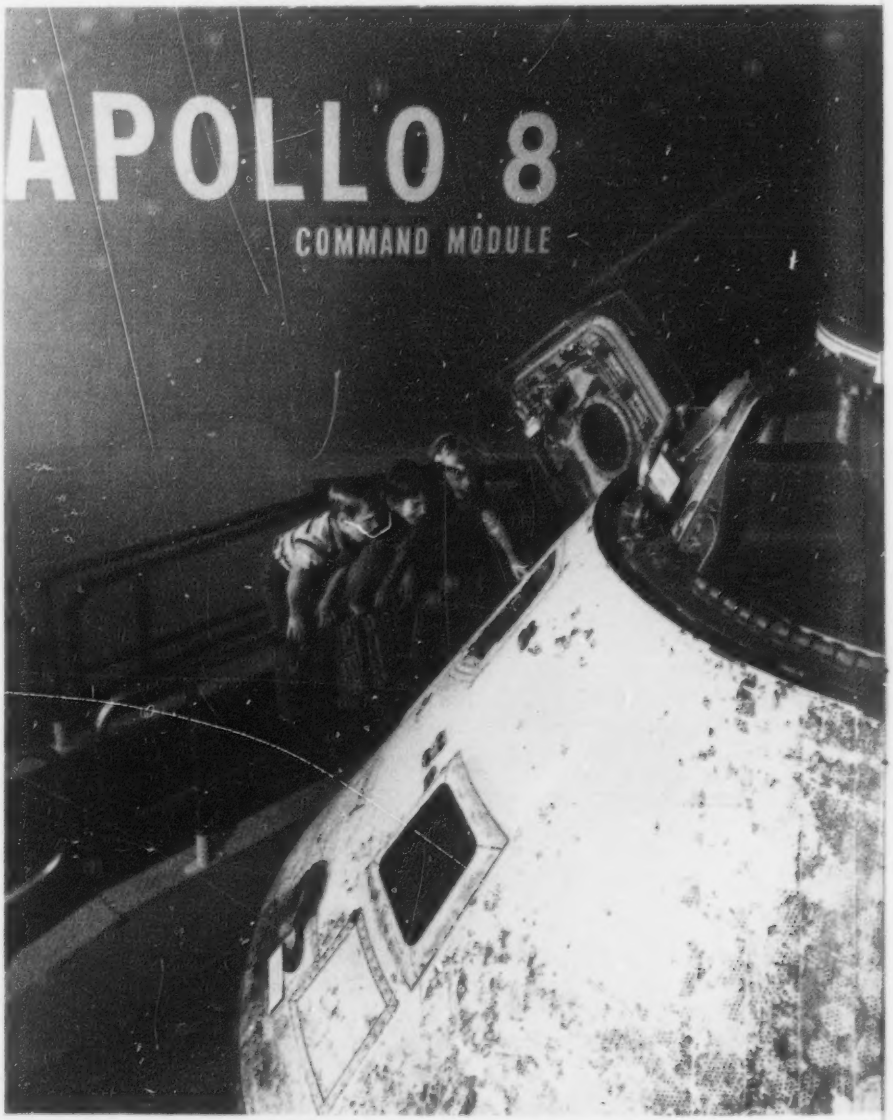
Seventy years ago, the family of Julius Rosenwald, a Chicago businessman, was vacationing in Munich, Germany. During the stay, Rosenwald's 8-year-old son visited a new type of museum which dealt with science and technology, emphasized the contemporary as well as the historic, and made extensive use of participatory and demonstration techniques.

The boy was fascinated by the machines that moved, the exhibits that could be touched and the exciting nature of the Deutsches Museum. He told his father about the wonderful museum and convinced him to visit it—a visit that led to the founding, in 1933, of America's first large museum of contemporary science and technology: the Museum of Science and Industry in Chicago. Today, the museum is the largest and most popular institution of its type in the world, serving some four million visitors from the United States and 100 other countries annually.

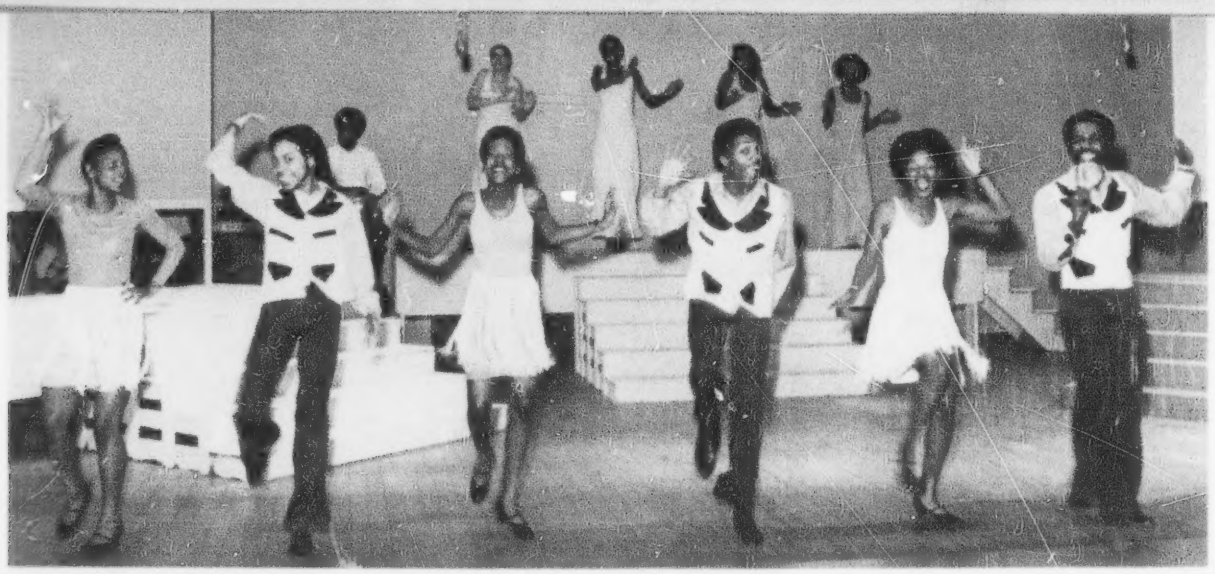
About half of the museum-goers are children who come to see the exhibits and science demonstrations in school groups, with their parents and friends and to attend such special events as the annual science fair, meetings with scientists and astronauts and special classes and field trips.

The museum has become a virtual fountain of discovery for young and

Victor J. Danilov is President and Director of the Museum of Science and Industry in Chicago.



The Apollo 8 spacecraft—the first to orbit the moon—is a popular attraction at the Museum of Science and Industry.



Some of the Museum's community activities, such as the Black Esthetics Festival, include theater performances as well as exhibitions.

old, student and teacher, layman and specialist. And just as the Deutsches Museum served as the model for the Chicago museum, the Museum of Science and Industry has spawned dozens of other museums in the United States, Canada, Mexico, Europe and the Orient. It was also instrumental in the formation of the Association of Science-Technology Centers, a nonprofit organization of science museums founded in 1973, which now serves more than 100 museums and related organizations in North America and abroad.

In Chicago, the museum has pioneered new participatory exhibit techniques, initiated the idea of industrial sponsorship of exhibits and programs, experimented with innovative educational offerings and developed broad-based community services. It has five primary objectives:

- To further public understanding of science, technology, industry and medicine.
- To explain scientific principles, technological applications and social implications in an informal, enjoyable manner.
- To preserve and interpret the nation's scientific, technological and industrial heritage.
- To acquaint young people with careers in science, engineering, industry, medicine and related fields.
- To present other appropriate cultural programs.

The museum is best known for some of its pioneering and long-term favorites: the operating "Coal Mine," which since 1933 has taken visitors into a full-scale reproduction of a southern Illinois coal operation; the U-505 German submarine captured during World War II; a 16-foot-high walk-through heart; a full-sized farmyard and barn; the "Fairy Castle" dollhouse; and a circus exhibit featuring 22,000 hand-carved animated figurines and a filmed circus performance.

Other exhibits included in the 75 fields covered are the "Nobel Hall of Science," describing the discoveries of American Nobel Laureates in physics, chemistry and medicine; a computerized exhibit that gives personalized information on the caloric and nutritional values of food; an exhibit that explains banking and economics through computer interactions; full-sized cutaway rooms showing plumbing with transparent piping; solar collectors that heat and cool parts of the building; and exhibits that explain human development and the fight against such diseases as cancer, heart problems and sickle cell anemia.

"Hands-on" Philosophy

Unlike many traditional museums, about 10 percent of the museum's exhibits change each year. Because of new developments in science and technology and the "hands-on" philosophy of the institution, exhibits become outdated and worn and must be rejuvenated periodically. In addition, new exhibits are added in fields not adequately covered. This year, for example, exhibits on newspapers, timekeeping, human development and communications were updated, while new ones dealing with basic science and electron microscopy were installed. The subjects of other new exhibits now being developed include everyday chemistry, hydroelectric power, natural gas, the nature and care of skin, preschool science and how to stay healthy.

The new "Grainger Hall of Basic Science," a major exhibition, replaces an outdated physics exhibit and covers physics, chemistry, biology and the earth sciences. Arranged in four parts, it offers a chronology of events that starts with the creation of the universe and ends with present-day science, weaving key scientific concepts into an exciting story that carries visitors through a 15-billion-year period.

The exhibit makes use of two main techniques—free-standing participatory modules and a "learning wall," consisting of panels with questions pertaining to the content of each section. For instance, modules allow the visitor to orbit a moon around the Earth, to simulate movement of the planets, and to answer questions on why the sky is dark at night and how many nuclear particles exist.

Because we wanted to be of greater service to very young children, who had difficulty in manipulating and understanding many exhibits, the museum initiated the preschool exhibit project, an experimental pro-

gram funded in 1980 by the National Science Foundation to develop, build and test some 25 prototype exhibit units that would be effective in communicating science concepts to children 3 to 6 years of age.

The result is a pilot exhibit designed to the scale, strength and comprehension of preschoolers and restricted to young children and their parents. Funds are now being sought to convert the concept and exhibits now on view into a permanent exhibition.

Science For Preschoolers

The cognitive objectives of the Preschool Exhibit were to encourage children to create relationships among events and objects; to further their ability to invent problems and look for solutions; to foster creativity—the ability to think of many different ways of doing something or of many different ways of using the same object; and to provide a basis for the later understanding of general principles and relationships.

From an affective standpoint, the exhibit designers sought to provide planned experiences which would increase children's confidence in their own ability to learn and to find out things for themselves; to stimulate curiosity and an enthusiasm for exploring and discovering; to foster initiative in looking for problems and solutions; and to provoke a sense of wonder and excitement about the physical world.

The exhibits developed cover a wide range of subjects and devices. A unit dealing with pulleys and inclines, for instance, consists of an 8x8x6-foot wooden frame with a variety of pulleys, a long and a short incline and a 3-foot-high platform. Four channels provide separate activity areas and bags and bottles filled with sand are available to be hoisted with the pulleys. We found this exhibit to be quite successful in producing good problems for children to solve and in stimulating their thinking about relationships at all levels. It also provides absorbing physical activity and is effective in fostering cooperation and exchange among the visiting children.

A double-swing exhibit in the preschool project, which also involves pulleys, has proved to be another

Above, flying an airplane and below, studying artifacts in the Museum's "Academic Interest Center" program, organized with the public school system.

Special programs for preschoolers are among the Museum's offerings.

good provider of a problem to solve and a relationship to be manipulated at all levels. It, too, stimulates cooperation among the youngsters.

Another unit—the gear unit—consists of a large board with drilled holes. Gears can be placed on the board by inserting a short length of dowel through the center of a gear and into the hole. Three sizes of gears are provided, some with pulley wheels mounted on their faces. In one corner, a bell, gear and hammer are permanently affixed to the board. The gear trips the hammer, which rings the bell. This unit provides a dominant activity for children ages 5 and 6, although they use it only briefly. It works best for a small number of children at higher age levels, producing activity periods of 30 to 45 minutes. (The tendency of gears to fall off the board contributes to brevity of interactions.)

In another unit, a model of a simple crane is large enough for a child to sit on and operate by turning a crank to raise or lower a weight. A friction brake holds or releases a weight and a set of pedals rotates the crane on its base. This unit produces sustained activity and dramatic play. The popularity of the crane, however, sometimes leads to children waiting for turns rather than being active elsewhere in the room.

A sand pendulum exhibit makes use of a funnel suspended from the ceiling over a black table surrounded by sand. Sand placed in the funnel traces Lissajous figures (any of an infinite variety of curves) when the funnel is allowed to swing freely. This pendulum is extremely successful in stimulating a wide range of sustained play. For younger children, the properties of the funnel proved to be most important; older children are more inclined to discover that the funnel/pendulum produces a pattern and to use the pendulum to experiment with pattern making.

Another exhibit—the harmonograph—was less successful. This involves a table suspended by four ropes from the ceiling onto which sand can be dropped through a funnel. When the sand is dropped onto the moving table, Lissajous figures are traced. This was not a successful exhibit because the children's interest in the sand and funnel eclipsed almost completely their interest in the motion of the table. The idea will be retested, using a pen for making the tracings, and the unit will be redesigned as a joint parent-child activity.

The final outcome of these and other designs and evaluations should be an effective and interesting, permanent science-oriented exhibit for preschoolers—something needed in many science museums and preschool educational programs.[1]

Parents have been enthusiastic about the exhibit. "It teaches them [children] to solve problems," stated one parent. Another said she liked "the idea of letting them experiment with their minds and imaginations and letting them share with you their experiences." A third parent said he was "totally impressed with the way the children are solving problems and working together."

Teachers also have praised the preschool exhibits, saying such things as "children found it intriguing—it made them think and figure things out while keeping them physically active" and "the children can really get involved and figure out reasons why certain actions cause a particular reaction."

Other Programs for Children

Other programs for young children at the museum include two class series. A variety of six different "Science Experiences for Preschoolers" are offered in three 1-hour weekday sessions. In these, 3-, 4- and 5-year-olds, and their parents, can explore books and materials dealing with light, water, machines and sound.

Classes for children in the lower as well as middle and upper elementary grades are offered on Saturdays. First- and 2nd-graders for instance, can find the answers to "What's Inside You" to learn how the body functions, or attend a 5-week session on "Rocks and Minerals," held in the museum, along the lakeshore and in the park.

"Family Classes," a series for elementary schoolchildren and their parents, offer a chance to explore, learn and experiment together, around such subjects as "Make Your Own Planetarium" or "Fossils: A Record of Chicago."

For older children, a more recent new emphasis has been on educational activities conducted outside of the museum. These include a series of field trips to research laboratories and industrial sites (a visit to the *Chicago Tribune* plant and one to the Fermi National Accelerator Laboratory in Batavia, Ill., on one Saturday, for example, and to a telephone switching center and an oil refinery, on another); and summer camp enrichment programs. This past summer, five outdoor living experiences were arranged by the museum. Fourth- to 6th-graders could attend "Farm Camp," where youngsters had an opportunity to live on a Wisconsin farm for a week, where they helped care for animals and learned about farm life and customs of the area, or

they could attend an "Outdoor Science Camp" at the Lorado Taft Field Campus near Oregon, Ill., where they participated in such science experiences as stream and weather studies, animal tracking, birdbanding, rock classification, fresh water ecology, astronomy and plant and animal identification.

"Canoeing in the Boundary Waters Area" of northern Minnesota gave 7th- and 8th-graders a chance to canoe, portage and tent outdoors, as well as to choose an area for nature study. High school students could take part in the "Geology Is" program that involved classes, outdoor activities and field trips, plus a week of tent camping near O'Fallon, Ill., to explore caves, quarries, riverbeds and mines.

In addition to these camp programs for children, an "Outdoor Educational Wilderness Leadership Workshop" was held at Lake Superior Provincial Park in Canada for teachers, youth leaders and other adults. The workshop sought to develop skills to enable adults to lead wilderness adventure experiences for young people.

Within the museum, other educational activities include science demonstrations—some 20 are given by museum guide-lecturers in such fields as simple machines, cryogenics, electricity, magnetism, lasers and optics and a variety of classes, films, lectures and special events, frequently presented in cooperation with area school systems, such as the "Academic Interest Center" in which two school classes from different parts of the city spend a week at the museum utilizing the exhibit halls as a classroom and laboratory.

This year a science fiction film and lecture series was scheduled for the first time. It included such movies as "Invasion of the Body Snatchers" and "Silent Running," with each film showing followed by a lecture and discussions relating science fiction to the real world and possibilities for the future.

The "Student Science Fair" of the Chicago Public Schools has been held at the museum for 31 years. It is one of the first and largest science fairs in the country. About 10,000 students participate and the 300 finalists are featured in a 4-day exhibit and program. (Twelve college scholarships are offered each year to winners in the Fair.) The "Non-public School Science Exposition," "Industrial Education Exhibition," "Home Economics Exhibition" and "Exceptional Children's Week Program" are

Museum exhibits and activities: opposite page, youngsters portage canoes in the summer camp program in the Minnesota Boundary Waters Area and, at the Museum, take part in a summer solar course; center, children look through a periscope, a part of the U-505 submarine exhibit; left, the "Fairy Castle" dollhouse, given to the Museum by silent mover star Colleen Moore; and below, exploring farm life in a summer camp program on a Wisconsin farm.

other annual museum events. The Chicago museum was also the first to hold a "Children's Science Book Fair," which now features about 1,300 books, including outstanding science trade books for children, as selected by a joint committee of the National Science Teachers Association and the Children's Book Council. And the first "Children's Science Library" is scheduled to open at the Museum of Science and Industry in 1983, under a recent grant of $200,000 from the Kresge Foundation. This past fall, the museum opened its new "Children's Science Laboratory," to be used by visiting classes for science demonstrations and for independent research by 6th- to 12th-graders.

Programs for Educators

To assist teachers, the museum distributes a teacher's guide to exhibits and programs and resource packets with questions, suggestions and activities relating to such subjects as energy, sound and hearing, simple machines, nutrition, mathematics and the heart. More than 100 booklets on fields represented among the museum's exhibits are also available.

Inservice workshops for teachers on the use of museum resources are offered, as well as 1- and 2-week summer workshops with college credit for elementary teachers on the use of nonformal resources in an inquiry approach to science teaching.[2]

Under a recent $350,000 grant to the museum from the Andrew W. Mellon Foundation, a science consortium will be established with 20 colleges and universities in the Chicago area to improve science teaching in elementary and secondary schools.

As a vehicle for informal science education, the museum seeks to complement the formal offerings of school systems and to help satisfy the growing public need for information about science and technology—presented in an understandable and interesting manner that captures the excitement of science.■

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[1] A summary of the evaluation of the pilot Preschool Exhibit is available from the Education Department, Museum of Science and Industry, 57th Street and Lake Shore Drive, Chicago, Ill. 60637.

[2] Information on the summer workshops for teachers and on obtaining the museum's educational materials are also available from the Education Department.

Day Treatment for Delinquent Youth: An Alternative to Residential Care

by Marlys Schutjer

We started our day treatment program for delinquent youths partly for the wrong reasons. We were weary of the problems and high costs that continually plague community-based residential child care programs—and we wanted to do something that would be more fun. Much to our delight, the day treatment program has resulted in better services to our teenage clientele, less disruption to their families and a dramatic savings of money.

There are many sound theoretical and practical justifications for day treatment. When I first described our answer to the skyrocketing costs of delinquency treatment, I was met with a polite, albeit cynical, jab: "If it's so great, why hasn't someone thought of it already?" Many people have thought of it, and have implemented variations on the theme during recent years. What hasn't happened, however, are national attention to the concept, availability of funding and a coordinated effort to highlight the idea and methods for its implementation. And while the day treatment program described here was designed for youngsters who had committed delinquent acts, day treatment is also suitable for use with other populations

Our program, the Francis L. O'Brien Center for Youth Development in Ann Arbor, Michigan, replaced its 6-bed community residential group home for adolescent girls with the day treatment program in 1977. It shares a ranch-style brick bungalow with an alternative education program—the Center for Occupation and Personalized Education (COPE)— for 60 young people.[1]

COPE is geared toward serving delinquent youths who live in their own homes and need individualized assistance in academic areas. Most are enrolled in the public schools—hanging on by their fingernails—and receive a maximum of six hours of individual tutoring per week at COPE.

Day Treatment Philosophy

A basic assumption of the Center is that delinquent behavior is closely linked to low self-esteem and that low self-esteem is closely linked to a youth's lack of skills and opportunities to engage in experiences normative for other youths in the community. We believed that the youths' self-esteem could be raised (and thus, their delinquent behavior reduced) by enhancing their skills and increasing their experiences.

Several realities and psychological dynamics implicit with this model help to assure its effectiveness:

- Non-labeling/positive expectations. The negative label that is attached to families whose teenagers have been removed from their homes militates against a young person's successful reentry into the community and home. When a young person is removed from his or her home, a change in self-perception takes place that may have devastating, long-lasting effects. Attending a day treatment program, however, is not very different from attending a public school or YMCA program in the eyes of the family, the community and the person himself.

- Neutralizing negative interaction between parent and teenager. Even in the healthiest of families with teenagers, a war can develop. Sometimes a respite period is required. Day treatment provides up to 55 time-out hours a week from these tense relationships. Initially, the parents and teenager may want to settle for nothing less than out-of-home placement so that the greatest possible distance can be placed between them. However, as the day treatment program progresses, these attitudes usually change. Through regular family therapy, problems are dealt with and many are resolved.

- Relevancy of treatment. By leaving the youth in the community, the treatment program must work with day-to-day problems that are directly related to the behavior that precipitated admission to the program. For example, a black ghetto youth may be unlikely to find viable solutions to his or her ultimate survival while living in a residential treatment program with white, middle-class youths. On the other hand, a teenager enrolled in a day treatment program, who is having problems in school will probably continue to attend that same school, but will receive help in problem areas from the day treatment program. If problems exist with the youth's neighborhood peer group, day treatment reduces the amount of contact and also helps the youth develop skills in interpersonal relationships. The living arrangement automatically provides the opportunity to test the young people gradually in the community—and feedback continues each morning.

- The incidence of running away drops to near zero.

Marlys Schutjer, M.S.W., is the former executive director of the Francis L. O'Brien Center for Youth Development, Ann Arbor, Michigan. Currently, she is a consultant to children's agencies, Division of Child Welfare Licensing, Bureau of Regulatory Services, Michigan Department of Social Services, Ann Arbor.

• Cost effectiveness. The O'Brien Center population was increased from six residential youths to 12 in the day treatment program, using the same basic staffing level. Except for sleeping provisions and weekend activities, the same services are provided to youths in the day treatment program as had been offered to residential youths. Space that had been used for bedrooms was converted to counseling offices, arts and crafts areas and study carrels, and there were savings on bedroom furniture, linens, laundry facilities and the clothing budget. Transportation costs rose dramatically with the day treatment model, however, offsetting some of the savings in other areas.

Cost effectiveness ultimately must be measured according to whether or not long-range costs have been reduced by successful completion of the day treatment program. Many factors must be included in this evaluation—court processing costs, intervention by social service agencies and detention/jail costs, for example.

By comparing residential care costs with day treatment costs, however, we find a significant savings. In 1981, the average cost to the Michigan taxpayer for placing one child in institutional/residential care for one year was $26,148. The comparable figure for day treatment was $19,000 a year for one program slot. The average stay in day treatment, though, was 6.8 months, resulting in a cost of $11,000 per child, while youths residing in the State Training School stayed an average of 346 days.

Sixteen percent of the youths enrolled in the day treatment program in 1979 were subsequently placed in residential care. The other 84 percent were able to avoid further court action subsequent to leaving the program. This is a simple counting process; there was no control group with which to compare these data, as there was no formal research study. The intake criteria, however, limited enrollment in day treatment to delinquent youth whom the juvenile judge and probation staff had specifically intended to place in out-of-home care if the day treatment program had been unavailable. It can be assumed that most of the youths fit this criteria and that a considerable cost savings resulted.

The Program

Program components were decided upon in a straightforward manner: We asked, what does a person need to survive in today's society? Our own biases determined the priorities: education first; "survival" skills, including employment preparation, second; and leisure time activities, third; with interpersonal skills permeating all areas. When a youth demonstrates responsible behavior in meeting program obligations, he or she is permitted to enroll in driver education—our most powerful incentive, more motivating than the threat of court action.

The program day begins at 9:00 a.m. (except for Friday mornings, which are reserved for staff meetings) and ends at 9:00 p.m. Educational pursuits are scheduled in the morning and early afternoon, recreation in the late afternoon, and counseling, cultural activities and arts and crafts, in the evening. Three meals are served daily, and daily chores are rotated weekly.

"By leaving the youth in the community, the treatment program must work with day-to-day problems that are directly related to the behavior that precipitated admission to the program."

Education

The major goal of this component is to help the youth graduate from public school, take part in the ceremonies and identify with that "normal" behavior. In order to be accepted into day treatment, a youth must be willing to enroll in an educational program of some sort. For most of the young people, this requires negotiating a split schedule between the same school from which he or she has been expelled, suspended or is still enrolled in, but failing, and the COPE (in-house tutorial) program.

After testing to determine the youths' functioning levels and problem areas, arrangements are made for them to take two of their most difficult courses in COPE. For most of the youths, reading and math are the major problem areas, so they are usually enrolled in public school for athletics, shop, art or music.

The Center works closely with school counselors and the young people to keep relationships open and responsive. A teenager who either refuses to return to public school or is refused readmittance could earn a high school equivalency diploma through tutoring. Those whose academic skills are too poor to tutor for a diploma are provided training in job skills, with an emphasis on occupational development. The 10 school districts in the county grant academic credit for all of the work done in COPE.

Some principles appear to be essential in a successful alternative tutorial program. Since most of the youths have had only negative learning experiences, they have closed their minds to the possibility that they can achieve. We have found that the young people must receive frequent, positive feedback, and that the instructional material must be carefully tailored to the youth's own level.

School work should never be used as a punishment—"If you don't behave, you're going to have to spend an hour longer in the classroom doing your homework." And frequent breaks should be allowed. (The Center schedules classes for 90 minutes a day, with breaks as needed.) Finally, several possible "classroom" areas should be available so that if a teenager is having trouble concentrating because of others in the classroom, he or she can be moved to a private area to work alone with a tutor.

Survival Skills

Areas covered in the survival skills component include job finding and job-behavior skills; money management; housing and transportation; comparison shopping; nutrition and meal planning; human sexuality; personal hygiene and etiquette; higher education; use of leisure time; and parenting skills. The teenagers are taken on field trips to demonstrate

the practical application of material covered in the written instructional units.

The post-test, or demonstration of a young person's mastery of survival skills, can be a program graduation exercise. Prior to release from the day treatment program, a youth is given a specified time in which to simulate an independent living experience. During this "exam" period of a week or so, the youth combs the newspaper ads looking for a job for which he or she would possibly qualify, arranges an interview and carries it through. Based on the assumption that the job is obtained, the take-home pay is calculated, a budget drawn up, apartment located, transportation arranged, household furnishings selected, a week's menu planned and leisure-time activities selected.

This component also has great potential for creative programming. The Center enlisted and trained a cadre of volunteers who work with the young people on a one-to-one basis, and, in some cases, form special relationships with them. The volunteers we have found to be most effective are those who have access to an automobile for field trips and who have been involved themselves in independent living. Some college students, for example, would be relatively ineffective in this role because they have not yet lived on their own.

Leisure-Time Activities

Teenagers have boundless energy and craving for excitement and many activities are needed to productively fill 12 hours a day, five days a week. It is necessary that staff members be very aggressive and creative at finding inexpensive or free activities. Everything done in treatment programs is a potential form of modeling behavior to the youth. Many delinquent acts are committed as a result of boredom, by those who do not yet know how to use their leisure time.

Daily recreational events include bowling, volleyball, skiing, ice skating, canoeing, swimming, roller-skating, touch football, water sliding and horseback riding. A favorite sport is downhill skiing (free lessons were provided by the parks department) and the opportunity for a ski trip has been an incentive that keeps the youth cooperating in other program activities all winter.

The value of a good recreation program became apparent when 350-pound, almost catatonic Elmer came to life for the first time. Elmer had spent most of his time lurking behind doors, hoping that no one would come through. He hid his head when anyone looked at him, never spoke audibly and probably was "stoned" 24 hours a day. There was no such thing as peer pressure for Elmer. He came to the program because of truancy (having also been truant from life for most of his 15 years).

His enrollment in day treatment seemed a waste of everyone's time—until one day Elmer discovered skiing. How he was persuaded to attempt it is not clear, but he did. By some miracle Elmer got all of his 350 pounds on skis and a courageous instructor took him on. By the end of the day Elmer was shussing down the hills with the best of them! The transition was exciting. Within a short time Elmer mustered enough self-confidence to drop by the administrative offices to chat. He began to look one straight in the eye and to hold his head up and his shoulders back as he walked.

"Teenagers have boundless energy and craving for excitement and many activities are needed to productively fill 12 hours a day, five days a week."

Special weekend and one-week activity trips are also planned—summer camping trips or a visit to a winter resort, for example, or a white water canoeing trip. To participate in some events, the teenagers are required to raise money by washing cars, picking up trash and holding bake sales. Friday afternoons are reserved for field trips to auto plants, art museums, botanical gardens and other sites of interest in Southeastern Michigan.

Counseling

Each youth is assigned a staff member "advocate," who is responsible for monitoring the youth's progress through the entire program and insuring that goals are met. This advocate is also responsible for individual counseling with the assigned youth, and for ongoing contacts with his or her parents.

The teenagers are divided into groups of six for group counseling, which takes place twice weekly. Staff members from such other community agencies as mental health, the Council on Alcoholism and Planned Parenthood are available as needed for special group or individual sessions.

Parent Groups

Parent discussion groups, held bi-weekly, have proved very successful in that they provide a support group of peers and treatment staff who do not view parents as failures because they are having problems with their teenagers. The groups also are used to teach parents various child management techniques and to share experiences relating to their teenager's progress and goals. Parents who are unable to attend group sessions are encouraged to participate in individual counseling sessions.

Possibly the one most important variable in the successful outcome of treatment of adolescents is involvement of the family in the youth's treatment program. Several very effective approaches used in residential care can be adapted for day treatment.[2]

Driver Education

Although the driver education class is a part of the COPE education component, it is mentioned separately here because of its importance as an incentive.

To be eligible for the class, a youth must read below the 6th grade level and he or she must present a documented reason as to why the course cannot be taken in the public school. Driver education is not *offered* to a youth entering the day treatment program. Rather, being accepted for the class is contingent upon the youth's modifying some behavior that is unusually resistant to change, such as beating up classmates or skipping classes.

The rules for the driver education class are very simple: "Miss class, use drugs or be obnoxious—you're

out. Always bring your materials to class or there's no point in your coming to class . . . and if you don't come to class, you're out."

The roughest, toughest youth in the county are meek and malleable during driver education. Abby, for example, had succeeded in terrorizing her entire school district—a bully who made it clear that she wanted nothing to do with school, with "white honkeys," with any behavior or attire that would identify her as a female, and with anybody who did not see things her way. When Abby reached 15½, for the first time she wanted something more than she wanted to be the "baddest bully": she wanted a driver's permit. Abby started attending classes regularly and stopped fighting and threatening everyone she encountered—conditions she had to meet to get into driver education.

Once in the class, Abby presented more surprises. She knew that she had a problem with losing materials, and that this problem put her continued enrollment in serious jeopardy. The obvious solution was to find a safe place at the Center to keep her materials so she wouldn't have to take them home every night and risk forgetting them the next day. After surveying the situation, she quickly selected the safest place: the "white honkey" director's office. But how?

Abby swallowed her pride for the greater good and "dropped in" to see me one day. As she passed the time of day her eyes darted all over my office until she spotted it—the "pending" basket on my desk! She steered the conversation around to what a fascinating basket it was, and what did I use it for? From there it was a simple move to asking, "Could I possibly leave my driver education book there after class each day?" Abby finished the class and regressed very little into her old habits. She surprised us all when she wore a dress for her "passing driver education" ceremony.

Other Program Considerations

Transportation. Because the youth sleep at home, they must live within reasonable proximity of the program. We chose a 25-mile radius, which extends to the farthest boundaries of our county. Transportation can be a major headache. Many enrollees live in outlying areas where public transportation does not exist. In the morning, those who are able to use public transportation are required to do so, and the others are picked up in a 15-passenger van. All of the teenagers are taken home in the evening, even when public transportation is available, to insure that they arrive home safely.

Transportation must also be provided for those who start their day in public schools and for recreational and survival skills field trips. Murphy's law tends to operate in transportation matters: it may be found that no two youths live in the same area, each attends a different public school and schedules are staggered, requiring that the driver be in six places at the same time.

"The roughest, toughest youth in the county are meek and malleable during driver education."

The Center employs one full-time and one half-time driver for the van, which logs an average of 150 to 200 miles each day. For the driver of the vehicle, those are not easy miles, since the teenagers often use this time to act out and be manipulative. As a result, the driver is required to be very skilled in human relations.

Rule Enforcement. Because ours is a day treatment program, we are not able to "ground" a youth for an evening or to limit certain weekend activities, or to search rooms for drugs or weapons. Thus, intake is limited to those who have no record of dealing in drugs or of assault with a deadly weapon. The Center rules are very few: "If you wish to be enrolled in day treatment instead of whatever else the court has in mind for you, you will attend every day and participate in all the required activities. You will not bring drugs or weapons with you to the program, nor will you consume drugs during program hours. If you violate these rules you will immediately be taken home and the violation will be reported to the court for whatever action it chooses to take."

Realistically, even this is not enforceable. The drivers do not have time to drive rule-violating youths home. Many of the youths' parents work all day and no one is at home. Finally, the juvenile court cannot take action on the staff's belief that a youth was "high," nor on such matters as non-attendance if it is only occasional.

Constraints to meaningful rule enforcement make programming an especially difficult challenge. The only truly effective lever is to create a program so exciting to the youths that it challenges their internal needs for growth, and is so reinforcing to them that the threat of being expelled from the program is sufficient to tone down aberrant behavior. The threat does not have to be used often, but it is implicit.

Organizational Structure. The Center is governed by a policymaking board of directors made up of 15 community members (either elected or appointed for rotating terms) representing the area school superintendents' association, the county board of commissioners, the juvenile court, the county labor council and the local department of social services. In addition, one slot is reserved for an attorney. The board has been a very powerful, active force in the survival and success of the program.

The organizational structure of the Center is traditional, with the executive director reporting to the board of directors, and a program coordinator for day treatment and one for COPE reporting to the executive director.

Conclusions

One advantage of a day treatment approach is its flexibility. Both boys and girls can participate in the same program without any special adjustments. Youths who cannot remain with their families may be placed in a foster family home in conjunction with day treatment, thus providing them with a home-like environment as well as structure, and at a reasonable cost. Those who could be ready for independent living but lack some needed skills and self-discipline could be enrolled in all or parts of a

(Continued on inside back cover)

Intellectually Handicapped Mothers: Problems and Prospects

by Steven A. Rosenberg and Gay Angel McTate

Few resources exist to help those with mental retardation deal with the problems of parenting. And this population is growing, as more and more mentally retarded citizens move into community settings and become parents.

Can mentally retarded people learn to be good parents? The answer is not simple and mental retardation is not the only issue involved.

As part of the Intensive Services to Families at Risk Project (ISFAR) at the University of Nebraska Medical Center, staff members worked with both retarded and non-retarded parents who had been referred for serious parenting problems. The main objective of ISFAR, a research and demonstration project funded between September 1977 and March 1981 by the Children's Bureau, ACYF, was to prevent the need for foster care by improving the quality of care abused and neglected children received in their own families. A wide range of service designed to produce improvements in parents' child care practices, including weekly home visits, group meetings and referrals to other agencies, were provided through the project.

About 10 percent of the 80 parents served through ISFAR were mentally retarded. Most of these parents were not willfully abusing or neglecting their children. However, through lack of knowledge and mistakes in judgment, they had not provided adequate care for them. Most were single mothers and, like most retarded persons who live in the community and have children, they were labeled borderline or mildly retarded.

It has become clear to us that for those considered to be in the borderline or mild range of retardation, I.Q. is not a good predictor of parenting ability. Parents with similar scores on intelligence tests can display substantial differences in commitment to their child and in their capacity to meet that commitment. For example, one mother dropped out of a long-awaited training program for herself because it interfered with her ability to bring her son to therapy appointments. She also delayed purchases for herself in order to buy toys and clothes for her son. Another parent however, resisted a necessary change in her son's educational placement because she liked the socialization available to *her* at his present placement and worried about the effect of the change upon her.

Concern for one's child can provide the motivation for parents to learn good parenting skills. For this particular population, concern and willingness to place a child's need ahead of one's own immediate wants are often more important predictors of the ability to improve child care skills than is intelligence.

"Few resources exist to help those with mental retardation deal with the problems of parenting."

Parents who are mentally retarded and referred for inadequate parenting share many characteristics with parents in the general population who have similar caretaking problems. Poverty, unemployment, lack of vocational skills, apathy, growing up with poor parenting models, isolation from extended family and social supports, lack of "normal" living experiences—in most cases, these are the same reasons and conditions that make it hard for persons who are not mentally retarded to be good parents.

Most of the mentally retarded parents we have served live on inadequate incomes, have limited job skills, are socially isolated and have few social supports. This lack of support is often due to conflicts with the extended family and to limited skills in making friends.

Another common problem which reduces their social supports stems from the tendency of parents with mental retardation to overtax the supportive people available to them. One single parent, for example, had a large extended family, whose members she took turns "visiting" so often that they finally refused to assume any responsibility for her and her child.

While mentally retarded parents may have somewhat greater difficulty learning new parenting skills, they can and do learn if they have a commitment to change and access to resources, social supports and training appropriate to their needs. All parents who neglect or mistreat their children need comprehensive services, including home visiting, skill training and group and social network supports, and mentally retarded parents are no exception.

While similarities of services and training needs for parents outweight the differences, parents who are mentally retarded do present some

Steven A. Rosenberg, Ph.D., is a psychologist at the C. Louis Meyer Children's Rehabilitation Institute, University of Nebraska Medical Center, Omaha. Gay Angel McTate, formerly a social worker at the Meyer Children's Rehabilitation Institute, is now with Family Enrichment, Inc., Omaha.

unique problems. First, the parents we worked with had a tendency to overgeneralize instructions. We found that we had to be very specific when explaining how to carry out responsibilities—it was not enough to help a mother change one or two aspects of her behavior and then expect her to improve other child care skills without additional assistance. One young mother, for example, who did not know how to cook, did not feed her child adequately and the child was not gaining weight. To teach cooking skills the worker and mother made pancakes together—and the mother proceeded to feed her child pancakes for breakfast, lunch and dinner.

Another challenge we encountered was the difficulty mentally retarded parents had in adjusting parenting styles to changes in their child's development. For instance, one mother learned certain games to play with her infant when he was nine months old. When the mother was visited a year later, she was still attempting to engage the child in the same games, even though they were now inappropriate for the child's developmental level. Consequently, parent training, both in the home and in groups, must provide specific instruction and follow-up to monitor how parents execute instructions and to modify them as necessary.

"Concern for one's child can provide the motivation for parents to learn good parenting skills."

The primary focus of our efforts has been to enhance the quality of care the children receive by addressing problems in the areas of child care knowledge, parent-child interaction, resources and family supports.

Problems in securing resources —particularly money, food and transportation—were common among the families and it was sometimes necessary for the project to offer direct assistance in the form of food supplies or a winter coat. More often, we helped the families locate resources in the community and assisted them in budgeting and managing other resources. Money management, preparation of nutritious and economical foods and monitoring of food supplies were topics for discussion during weekly home visits and some group meetings.

We also assisted families in negotiating the complexities of the human services system, using role-playing techniques to demonstrate how parents can advocate for themselves in various situations—meeting with their child's teacher or talking to a landlord, for example.

Generally, role play began by talking about the purpose of an appointment and considering the kinds of questions that the parent might ask or be expected to answer. Parents would practice asking questions of a staff member pretending to be a landlord or social worker and learn appropriate phrases to use. We would also talk about how the parent should dress and discuss the importance of maintaining eye contact.

Initially, a worker accompanied parents to appointments and, afterwards, discussed the experience with them. It was sometimes necessary to encourage a parent to ask more questions or to simply say, "I do not understand what you mean." Many parents did gradually increase their ability to advocate for themselves without the need for reminders or corrections, and as they became more confident, it was no longer necessary to accompany them to appointments. As their confidence in their ability in other areas increased, their self-advocacy skills also increased.

Group Activities

Activity groups focusing on skill learning, problem solving and support proved to be very useful. All of the mothers were involved in at least one group.

A mother-child swim group that met weekly for six weeks at Meyer Children's Rehabilitation Institute was designed to improve the quality of interaction between parent and child. In small, highly supervised groups, mothers and children engaged in mutually enjoyable aquatic activities. Staff members modeled and demonstrated talking with the children and holding them so that they felt safe. Parents were able to teach their children to enjoy the water by gently encouraging them to come into the water and by holding them so that they could float. As parents gained competence in handling and playing with their children in the water, they also gained a new and positive image of themselves.

Staff members also used the swimming group as an opportunity to teach parents how to dry and dress wet, squirming children. As in other groups, parents learned from each other. One parent who had successfully used a "find the hand" game to enlist her child's cooperation in dressing encouraged two other parents to use this strategy.

A second group, which met regularly for more than a year, was devoted to discussions and demonstrations of appropriate child care procedures. Topics covered here included discipline, safety in the home and toilet training. Instructions were given in a more concrete manner than ordinarily used in parent education groups. In most parent groups, information is given in general statements: "Children of 10 months put things in their mouths." While parents who are retarded may understand the words, they might not be able to translate such a statement as meaning, "Do not leave small items on the floor."

"Activity groups focusing on skill learning, problem solving and support proved to be very useful."

Thus, during a session on "child-proofing" a room, the group first talked about how it could be done and then practiced by going into a mock living room and child-proofing it for children who could crawl, who could walk and who were able to climb. Whenever possible, group leaders modeled ways of observing

changes in a child's development and modifying their responses to fit those changes.

A substantial amount of time was spent in addressing problems raised by parents, including their frustration at being treated as inadequate parents without knowing what they were doing wrong, or even when they were performing well. Often this situation occurs after the parent begins to provide better physical care. Workers recognize the improvement but are uneasy about the ability of mentally retarded persons to provide adequate parenting. They may then become concerned about the child's intellectual and emotional needs but have difficulty in putting this concern into concrete terms for the parents.

". . . for those considered to be in the borderline or mild range of retardation, I.Q. is not a good predictor of parenting ability."

The group discussions also encouraged parents to share experiences and learn from one another. When one mother mentioned that she had punished her small child by standing him in a corner for hours—a strategy that she had learned when she was in an institution—group members suggested less harsh disciplinary procedures.

Group participation also had the effect of increasing social support. We discovered early that even if the group focused on child care, part of each session should be directed toward meeting the parents' social needs. We eventually lengthened the group time and spent the first 30 minutes on such topics as personal grooming, talking to strangers and the responsibilities of friendship.

Friendships formed among some parents and led to telephone visits between meetings. This socialization was important for promoting self-worth and for providing an emotional outlet and relief from isolation and loneliness.

A third group, a mother-child play group, also met weekly. During these sessions, staff members introduced parents to new toys and helped them learn to use them in play with their children. The sessions provided opportunities for the kind of playful interactions between parents and children that rarely occurred elsewhere for these families. Parents were able to see leaders modeling appropriate play behavior and, at the same time, they had some of their own needs for play fulfilled. The play group also offered an excellent forum for demonstrating ways of handling discipline problems.

On one occasion, for example, a mother had considerable difficulty toileting her 3-year-old. The child's cries could be heard quite clearly by other parents and when she and her son returned from the bathroom, the group leader asked her what had happened. The mother explained that her son wanted to play with a toy in the hall instead of going into the bathroom, and when she dragged him in , he began to cry. She was also frustrated with the difficulty of getting her son into the bathroom and undressed before he wet himself. During the following meeting one worker took charge of the children while the other leader and mothers moved to another part of the room to work on the problem. Some alternative strategies for toileting were suggested, and the group leader and the mother tried them out at home later that week. At the following session, group members applauded the mother when the toileting trip was accomplished with much less conflict.

"Over long periods we saw important changes in some of the mothers."

Home Visiting

During home visits, workers focused on helping the mothers integrate information from the group sessions and apply it to situations in the home. The home visits also provided opportunities for workers to model appropriate techniques and clarify information.

Part of each home visit was also devoted to the parent's personal concerns, such as conflicts with friends or family and money problems.

". . .more than half of the families are doing well with no continued services."

The capacity and the needs of our families varied, and in some instances it was appropriate to involve members of the extended family or of the families' social network to help improve a mother's child care skills. For example, one of the mothers had difficulty giving her son necessary medication. We developed a useful method but believed the mother needed daily coaching in order to learn a new way of dealing with her child's resistance. We invited her sister to a home visit and demonstrated the technique, and the sister agreed to assist the mother until she could carry it out successfully.

Members of the extended family were also occasionally invited to group meetings. Contact with the parents' families and friends was important in strengthening the network and making needed support available. Sometimes this involved resolving conflicts or working out living arrangements. Occasionally, it resulted in the extended family assuming responsibility for the child when it became clear that the client did not have this capacity.

Since the parents' network also included professionals working with the family, it was often necessary to coordinate the activities of several service agencies.

Individual Counseling

In individual sessions with clients, basic living skills—personal hygiene, greeting people and appropriate street behavior, for example—were discussed. At the request of several

(Continued on inside back cover)

NEWS & REPORTS

ACYF Commissioner Named

Clarence E. Hodges, formerly Assistant Director of the Community Services Administration and Director of the Office of Community Action, has been appointed Commissioner of the Administration for Children, Youth and Families and Chief of the Children's Bureau. He was nominated for the post by President Reagan and confirmed by the U.S. Senate in December, 1981.

Before joining the Community Services Administration last year, Hodges, 42, served as staff assistant to Senator Richard G. Lugar (R., Ind.). In 1980, he was a candidate for the U.S. House of Representatives from the 11th District of Indiana.

From 1973–1977, Hodges served as Director of Human Resources for the City of Indianapolis, as Assistant to the Mayor for Human Relations and as Assistant Executive Director of the city's Housing Authority. Between 1967–1973, as Executive Director of the Concentrated Employment Program for St. Louis, Missouri, Hodges directed employment and training programs sponsored by the U.S. Department of Labor. He has also been a casework supervisor for the Missouri Division of Welfare (1962–66).

Hodges received a B.A. degree in Public Administration from Upper Iowa University and a M.A. degree in Urban Studies from Occidental College. A native of Princeton, North Carolina, he is married and has four children.

Child Abuse Grants

The National Center on Child Abuse and Neglect in the Children's Bureau, ACYF, has awarded $4.7 million in grants for 59 projects. The grants, made to public and private nonprofit agencies at state and local levels, are designed to expand current knowledge of the causes and treatment of child abuse and neglect and to develop new approaches that states and communities can use in preventing child maltreatment.

The projects fall into the following major categories:

- Prevention programs by hospitals and other health facilities to provide supportive services to families before and after the birth of their children to alleviate family stress and strengthen parent-child relationships.
- Treatment of abused and neglected children with emotional disturbances, by coordinating services of mental health centers and child protection agencies.
- Research on child neglect and maltreatment of adolescents.
- Prevention and treatment of child abuse in minority groups, with emphasis on sensitizing caseworkers to differing cultural and child-rearing practices in minority families.
- Treatment of children living in shelters for battered women.
- Inservice training of child protective services personnel.

A list of grantees may be obtained by writing to the National Center on Child Abuse and Neglect, P.O. Box 1182, Washington, D.C. 20013.

Incidence of Child Abuse

According to a study released by the National Center on Child Abuse and Neglect (NCCAN), a minimum of 625,000 children in the United States are abused and neglected each year—a figure considerably lower than the generally acknowledged estimate of about a million cases a year.

NCCAN officials note, however, that the definition of abuse and neglect in the study applied only to children who suffered demonstrable signs of physical or emotional harm. Excluded were children who were suspected of being abused or neglected but showed no overt signs of maltreatment and children considered to be at risk of abuse or neglect—the types of cases that often come to the attention of protective service agencies.

The incidence estimate of 652,000 abused or neglected children translates into an annual rate of 10.5 maltreated children for every 1,000 children under the age of 18 in the United States.

The study was conducted by Westat, Inc., Rockville, Md., under contract with NCCAN. The first to use uniform definitions of abuse and neglect in collecting national data on child maltreatment, the study was carried out in a random sample of 26 urban, suburban and rural counties in 10 states. Data on abuse and neglect cases was collected over a 12-month period in each county from child protective service agencies and selected county agencies, including schools, hospitals, courts and police departments.

Contrary to a common assumption that young children are the primary victims of maltreatment, the study found a higher incidence of abuse and neglect among adolescents: 14.3 cases per 1,000 15- to 17-year-olds, compared to 8.3 cases per 1,000 preschool children.

While the incidence rates were identical for black and white children, the study found more abuse and neglect in low-income families than in higher-income groups. This finding, the researchers point out, may corroborate the theory that economic and related family stresses can lead to child maltreatment.

Only about half of the children counted in the study were reported by child protective services—the agencies designated to receive official reports of abuse and neglect. According to the researchers, this finding indicates that many abused and neglected children known to doctors, teachers and others in the community are not being officially reported, despite state laws mandating such reporting by professionals.

Single copies of *Study Findings:*

National Study of the Incidence and Severity of Child Abuse and Neglect (Pub. No. (OHDS) 81-30325) may be obtained free from LSDS, Dept. 76-A2, Washington, D.C. 20402.

Dennis the Menace

Dennis the Menace, that lively and lovable comic strip character, can also irritate his parents and nextdoor neighbor—and Dennis often cannot understand why they react as they do. In *Coping with Family Stress*, a comic book published with funds from the National Center on Child Abuse and Neglect (NCCAN), Dennis' antics are used to give parents helpful hints in dealing with some typical situations that can be aggravating to both parent and child.

When Dennis' bid for attention is ignored by his busy parents, for example, Dennis knocks on the neighbor's door, only to be rebuffed when he hears Mr. Wilson tell his wife that it's "Just whatsisname from next door." "Nobody can see me ... I must be disappearin'," Dennis thinks as he returns home—and, muttering to himself, "Hate to do this, but ...," he smashes a dish on the floor. Finally, Dennis gets the attention he craves when he and his teddy bear are placed in the corner. "I'm back," Dennis sighs.

Situations are introduced with an explanation of the stress point illustrated—in this example, that an adult's frustration in trying to get something done can lead to behavior that affects the way children feel about themselves—and conclude with a possible solution. Here, the comic book points out, "When children feel neglected, they may go to extremes to get attention." It suggests that if parents can't include children in what they're doing, they should explain that "we'll get together ... when we're free to do so."

The importance of understanding what lies behind a child's—and an adult's—behavior is emphasized throughout the book. And it also reminds parents that there's no better cure for stress than a good laugh.

The comic book was illustrated by Hank Ketcham, Dennis' creator, and published by Field Newspaper Syndicate under contract to NCCAN.

Parents who want information on giving or receiving help to prevent child abuse and neglect are referred to one of the 10 Regional Resource Centers on Child Abuse and Neglect, which are listed on the back page.

Coping with Family Stress is available in English and Spanish. Single copies may be obtained free by writing to Dennis the Menace, National Center on Child Abuse and Neglect, P.O. Box 1182, Washington, D.C. 20013.

Model Adoption Act

Model state legislation to encourage the adoption of children with special needs has been issued by the Department of Health and Human Services. The model act, mandated under Title II (Adoption Opportunities) of the Child Abuse Prevention and Treatment and Adoption Reform Act of 1978 (P.L. 95-266), was published in the *Federal Register* on October 8, 1981.

The legislation—the Model Act for the Adoption of Children with Special Needs—provides for financial assistance to make possible the adoption of any child with special needs; expands the grounds for adjudications freeing such children for adoption; and clarifies the roles of adoption agencies and state adoption administrations in arranging and providing support services for adoption.

Single copies of the legislation may be obtained free from the Children's Bureau, ACYF, P.O. Box 1182, Washington, D.C. 20013.

Young and Old

Through an interagency agreement, volunteers from ACTION's Foster Grandparent Program and Retired Senior Volunteer Program (RSVP) have begun working in Head Start programs in nine areas of the country.

In the year-long demonstration program, some 600 RSVP volunteers are serving as teacher aides in classrooms, assisting staff members in providing health, social and nutrition services to Head Start children and parents and helping with a variety of managerial and secretarial tasks. Forty-five Foster Grandparents have been assigned to work with handicapped children in Head Start classrooms.

The project will develop different models for using older volunteers that can be adapted by Head Start centers nationwide.

The demonstration program was made possible through the transfer to ACTION of $275,000 in Head Start funds from ACYF. Foster Grandparents receive a small stipend for their services, while RSVP volunteers are reimbursed for work-related transportation expenses.

The six RSVP programs participating in the demonstration project are RSVP of Lee County, Fort Meyers, Fla.; RSVP of Joliet Area, Joliet, Ill.; RSVP of North West Arkansas, Fayetteville, Ark.; RSVP of Pennington County, Rapid City, S.D.; RSVP of Montgomery County, Wheaton, Md.; and RSVP of Ada County, Boise, Id. The three Foster Grandparent grantees are Foster Grandparents of Tri-County, Soquel, Calif.; Foster Grandparents of the State Department of Health and Human Services, Madison, Wis.; and Foster Grandparents of Economic Opportunity Atlanta, Inc., Atlanta, Ga.

Photo: ACTION

A Foster Grandparent volunteer conducts playground activities with preschoolers.

Starting a Day Care Center

The challenging business of *How To Start A Day Care Center* is the title and subject of a new booklet published by the Day Care Council of America. The 48-page guide was prepared by the Day Care Council with funds and assistance from ACYF and the Office of Policy Development in the Office of Human Development Services, DHHS.

The booklet focuses on the practical aspects of starting up a center: licensing, zoning and other regulations; assessing specific day care needs of parents in the community; deciding whether to operate as a profit or nonprofit center; locating and leasing space; obtaining furniture and equipment; writing job descriptions; hiring staff; and preparing a budget. And to help prospective entrepreneurs decide whether they have the stamina and capabilities to operate a small business, the booklet begins with a questionnaire and analysis developed by the Small Business Administration (SBA).

Noting that public funds are seldom available for starting a center, one chapter lists some prospective funding sources, including the SBA, and discusses the types of information that loan officers are likely to want. The SBA, for example, recommends that applicants "have at least 20 percent of the money you want to borrow."

Checklists at the end of each chapter specify tasks to be accomplished during each phase of establishing a center, and a summary chart outlines the major tasks, with the estimated number of days it will take to complete each one. While the average start-up time is one year, it could be accomplished in half the projected time "by concentrated planning," the booklet points out.

Included in the appendix are a list of state day care licensing offices; a glossary of banking terms; a chart of recommended furniture, toys and equipment; and a sample job description for a day care teacher. Publications on such topics as child development, program content, parent involvement, center design, fund raising and proposal writing are listed in the annotated bibliography.

The guide was developed with assistance from day care providers, state day care licensing personnel, representatives from universities, federal agencies and national organizations, and staff members from the Small Business Administration.

Copies of the booklet are available at $4.95 each (plus $1.00 postage and handling) from The Day Care Council of America, Inc., 711 14th St., N.W., Suite 507, Washington, D.C. 20005.

Resource Center Established

The Children's Bureau has awarded a $264,000 grant to create a National Resource Center on Family Based Services. Designed to help states and communities develop programs to reduce the numbers of children entering foster care, the Resource Center will be operated by the National Clearinghouse on Home Based Services for Children at the University of Iowa School of Social Work, Iowa City.

A handbook for use by states will be prepared, outlining different strategies for using child welfare funds and services to prevent family breakdown. The Resource Center will also disseminate materials gathered by the Clearinghouse over the past four years on existing family-based service programs.

During its first year of operation, the Center will provide technical assistance to three states that are reorienting their child welfare programs away from extensive use of foster care to services to prevent foster placement and reunify families.

Additional information on the project may be obtained from the National Resource Center on Family Based Services, National Clearinghouse on Home Based Services for Children, School of Social Work, University of Iowa, Iowa City, IA 52319.

TV and Deaf Children

Helping deaf children to understand the uses of captions in TV programming is the goal of *Captain Marvelous*, a 15-minute videotape produced by the Multi-Level Captioning Project at the Caption Center, WGBH-TV, Boston. Featured as the star and superhero is Bernard Bragg, actor, director and co-founder of the National Theatre of the Deaf.

Intended for use in a variety of educational settings, the videotape is accompanied by a 3-part "Caption Kit" containing a workbook for students; a teachers' manual explaining ways to use captioned media in the classroom and dormitory; and a brochure for parents discussing the skills deaf children need in order to get the most from captioned materials.

Since 1977, the Multi-level Cap-

tioning Project—which is funded by a grant from the Office of Special Education, U.S. Department of Education—has conducted research on deaf children's reading abilities and captioning needs. *Captain Marvelous* was developed in response to studies indicating that despite the boom in TV captioning for the deaf, children are often confused by words on the screen and sometimes fail to connect them with spoken dialogue. The project has also developed a system for editing language, described in *Readable English for Hearing-Impaired Students*, which has been used to caption more than 40 episodes of popular commercial programs at one or all of three distinct reading levels.

Bernard Brace as "Captain Marvelous." Photo: Jeff Dunn for WGBH

Staff members of the project are available for workshops, consultation to schools and other organizations serving the deaf and for demonstrations of the "Caption Kit."

Information on ordering the videotape and "Caption Kit"—available in March—and *Readable English for Hearing-Impaired Students* may be obtained from Betsy Montandon, Supervisor, Multi-level Captioning Project, The Caption Center, WGBH-TV, 125 Western Ave., Boston, Mass. 02134.

Caries Prevention

Proceedings of a symposium, "Dental Caries Prevention in Public Health Programs," has been published by the National Institute of Dental Research.

The proceedings contain transcripts of the presentations and discussion sessions from the 2-day meeting, held in October 1980, which was sponsored by the Institute's National Caries Program. Included are papers covering the history, efficacy and safety of water fluoridation; alternative methods of delivering fluorides and aids for implementing self-applied fluoride programs; the role of sugars in dental caries; and new technologies to prevent dental caries.

Single copies of the proceedings (Pub. No. (NIH) 81-2235) are available free from the National Caries Program, National Institute of Dental Research, Westwood Bldg., Rm. 549, 5333 Westbard Ave., Bethesda, Md. 20205.

Respite Care

For This Respite, Much Thanks, a 144-page manual published by United Cerebral Palsy Associations, Inc. (UCPA), describes a variety of respite care programs that are helping families to care for a disabled member at home.

The manual is the result of a 2-year project, conducted by UCPA and the Special Education Development Center of the City University of New York, that examined four effective community programs and surveyed 15 others for successful approaches in starting and operating respite care programs. The project was funded by the Bureau of Developmental Disabilities (now the Administration on Developmental Disabilities), DHHS.

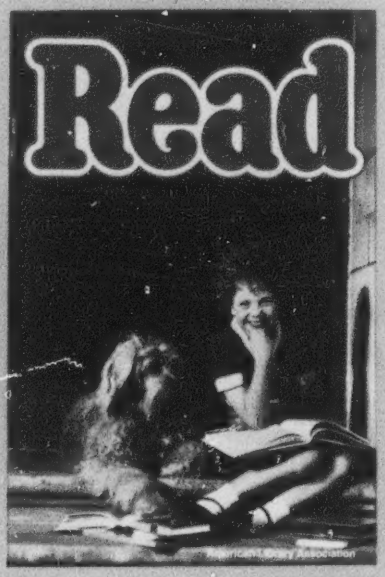
Issues and questions to consider in planning respite care programs are discussed, together with suggestions for obtaining funds, deciding on models of care, involving parents and selecting workers. The manual also includes sample guidelines, agreements and surveys developed by the programs.

Single copies of the manual may be ordered at $3.00 each from United Cerebral Palsy Associations, Inc., 66 E. 34th St., New York, N.Y. 10016.

National Library Week

For National Library Week—April 18-24—the American Library Association has prepared publicity kits containing a variety of materials to help promote the theme, "A word to the wise—library."

In addition to a new READ poster featuring Little Orphan Annie and her dog Sandy (created with the cooperation of Columbia Pictures during the filming of *Annie*), three other posters have been designed. One, cut out of a big blue jogging shoe, carries the caption, "Jog your mind, run to the library"; a second poster, cut out of a large orange pencil, is captioned, "Read before you write, use your library." The third poster shows a multi-colored cut-out of the word "library" with the line, "A word to the wise," running underneath it.



Publicity kits also include samples of news releases, public service announcements, proclamations, editorials and ideas for year-round promotion of the materials.

Information on ordering the 1982 kits and materials from previous years (all undated) may be obtained by writing 1982 Library Graphics, Public Information Office, American Library Association, 50 E. Huron St., Chicago, Ill. 60611.

Combating Delinquency

In 1977 in Richmond, California, members of the Black Lords—a youth gang operating in Easter Hill Village, a public housing project described as the "ghetto's ghetto"—were recruited into a new Boys Club demonstration program. Last summer the former gang members ran a day care program for Village residents, and through big brother-type activities, they work to keep youngsters in the Village out of trouble.

Teenagers in Omaha, Nebraska, went door-to-door in their neighborhoods taking blood pressure readings and advising occupants of the dangers of hypertension and the availability of treatment. And in Las Cruces, New Mexico, Boys Club participants organized weekly "family nights" at a neighborhood school, offering a variety of activities—parenthood education classes, guitar lessons, drama and arts and crafts, for example—for parents and teenagers.

These are among the projects undertaken as part of the Boys Clubs of America National Project on Juvenile Justice, a 3-year (1977–79) demonstration program funded by the Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice. Conducted in nine sites during the first year and expanded to 21 additional communities, the program focused on preventing and reducing juvenile crime in neighborhoods with high juvenile crime rates.

Local club staff members, who received training and technical assistance from Boys Clubs national headquarters, incorporated delinquency prevention objectives into traditional Boys Clubs programs emphasizing peer leadership, job training and work experience, community service and group counseling and recreational activities. "Wilderness Counseling," in which youths learn self-reliance and confidence through mountain climbing, rafting, camping and survival training, was also included in several of the programs. Enhancing the youths' self-esteem was a major goal of all of the projects.

As part of the National Project on Juvenile Justice, several Boys Clubs programs established day care centers for children in their communities.

Some 6,400 boys and girls participated in the nine pilot projects and another 35,000 youths were served in new programs that evolved from the original demonstration sites. About one-third were referred by the courts or police, while the others were recruited by outreach efforts. About 20 percent of the teenagers had been arrested at least once—usually for a misdemeanor or status offense.

An evaluation of the program, conducted by Mira Associates, Boulder, Colo., found that in eight of the cities where pilot projects were conducted, juvenile arrests dropped 27 percent. (During the first year of the project, arrests of juveniles nationwide increased nine percent.) Boys Clubs officials note, however, that many factors influence arrest patterns and that no single service alone can take full credit for the reduction.

The evaluation also found the approach of incorporating preventive principles into existing programs, rather than concentrating on specialized prevention services, to be effective. "Good ones [Boys Clubs] that conscientiously and consistently provide troubled youth with positive experiences for personal growth and provide roles for youth's active and meaningful participation in Clubs, are models for effective prevention," the evaluator's report states.

Local agencies have picked up funding for most of the demonstration projects, and several smaller "satellite" programs have been initiated. In cooperation with other community agencies, 34 Boys Clubs in three states—Louisiana, New Mexico and Michigan—have launched statewide juvenile delinquency prevention efforts.

In addition to providing training and technical assistance to local Boys Clubs workers, the Boys Clubs of America has developed juvenile justice program resource materials and, in 1980, established a Juvenile Justice Resource Center to collect and disseminate information and materials.

A final report on the project, together with information on the Resource Center, may be obtained from John Badger, Program Director for Juvenile Justice, Boys Clubs of America, 180 Grand Ave., Suite 900, Oakland, Calif. 94608.

Arts in Education

The Arts, Education and Americans, Inc. (AEA), a national nonprofit organization working to strengthen the role of the arts in schools, has published 10 monographs for educators, arts organizations, community leaders and others interested in continuing and/or expanding the arts in schools. Produced in cooperation with Educational Facilities Laboratories, the monographs are part of

an ongoing National Advocacy Program for Arts in Education sponsored by AEA. The Advocacy Program is based on the premise that arts programs are basic to individual development and part of the essential fabric of schooling.

One monograph, entitled *People and Places: Reaching Beyond the Schools* (Report #1) examines how schools can join forces with artists and arts organizations in the community to stretch available resources and expand experiences for students. In *Arts in the Curriculum* (Report #8), the ways in which arts can be incorporated into such subject areas as math, language arts, science, shop and history are described while in another, *Creative Collaborations: Artists, Teachers, and Students* (Report #2), guidelines are provided for developing alliances with professional and amateur artists.

Other monographs in the series are: *Your School District and the Arts: A Self-Assessment* (#2); *Local School Boards and the Arts: A Call for Leadership* (#3); *Ideas and Money for Expanding School Arts Programs* (#4); *Method and the Muse: Planning a School Arts Program* (#5); *Developing Financial Resources for School Arts Programs* (#6); *The Case for Arts in Schools* (#7); and *Arts in the Classroom: What One Elementary Teacher Can Do* (#10).

The monographs ($2.00 each per single copy, less in quantity) and additional information on the Advocacy Program may be obtained from The Arts, Education and Americans, Box 5297, Grand Central Station, New York, N.Y. 10163.

Two Bibliographies

Teenage pregnancy and parent involvement are the subjects of two bibliographies available through the Office of Elementary and Secondary Education, U.S. Department of Education:

- *Selected Publications on Adolescent Sexuality, Pregnancy and Parenting (1965 to Present)*, which lists more than 75 books, reports and abstracts on the subjects.
- *Parent Involvement Programs at Elementary and Secondary Levels*, which identifies more than 100 articles and reports published between 1973 and 1978.

Copies of the bibliographies may be obtained free by writing to Leona Chazen, Education Support Specialist, Parent/Early Childhood and Special Programs Staff, School Improvement Programs, Office of Elementary and Secondary Education, U.S. Department of Education, 400 Maryland Avenue, S.W., Dono 1628, Washington, D.C. 20202.

Correction

The address given for the National Center for Clinical Infant Programs in our July-August 1981 issue should have read 733 - 15th St., N.W., Suite 912, Washington, D.C. 20005.

BOOKS

Fathers

Ross D. Parke, Cambridge, Harvard University Press, 1981, 136 pp., $8.95 (cloth), $3.95 (paper).

Reviewed by Edith H. Grotberg

Fathers is the most recent publication in The Developing Child series edited by Jerome Bruner, Michael Cole and Barbara Lloyd. This contribution to the series is much needed and well done. Ross D. Parke has combined a broad knowledge of the behavioral and social sciences, an increasing ecological perspective and skills in research issues to help him address this still unusual topic.

Parke is fully aware of the mythologies and early so-called scientific theories about the role of fathers in the development of children. He is able to sort out stereotypes, drawing on research findings and comparative analyses of social customs and behavior.

The book examines myths about fatherhood and attempts to counter them with realities. The limiting aspect of this effort continues to bias most research. Thus, when research on fathers' play behavior with children as compared to mothers' is examined, or when the differential treatment of fathers toward their girls as compared to their boys is studied, the findings reflect current biases: Fathers engage in more "rough house" play with their children and interact more with their sons than with their daughters.

Because the largest body of research available to draw on for the book is descriptive, the findings tend to conform to cultural expectations. The emphasis on descriptive data is not a criticism of the author; it is a fact of much social science research.

Parke draws heavily on descriptive research to address issues surrounding such areas as the expectant father, fathers and infants, divorce and custody and the social and intellectual contributions of fathers. Observable behaviors are described in each of these areas and questions raised about alternative ways fathers might behave. Parke draws on anthropology and descriptive studies of other forms of fathering behavior to counterpoint the biases in the traditional descriptive studies.

There is an excellent treatment of changes in society, including divorce and the increasing number of single parent families, which force many families to reexamine sex roles and parental responsibilities. Parke includes some studies of alternative arrangements involving shared childrearing responsibilities, reversed traditional sex roles or combined sex roles, but again is limited mainly to descriptive studies.

The final chapter, "Innovations in Fathering," is a major attempt to

draw on experimental research and suggest new roles appropriate to the new image of fathers. However, the limitations of available research and the tendency for so much research to follow and describe events rather than experiment with new behaviors weakens the effectiveness of the chapter. Thus, Parke is placed in the position of advocating for more father involvement in the care and development of children, rather than reporting on research. This advocacy approach is not uncommon when data are unavailable. But, perhaps, the appeal should be for more creative research on ways fathers can engage in and enjoy their participation in the lives of their children. Also, considerable research is needed to examine the resistance of many mothers to father involvement.

This reviewer attended a White House meeting a number of years ago to discuss psychosocial development of infants. During the 3-hour session, fathers were not mentioned once; discussion focused on mother-infant bonding, and maternal-child health. When someone posed the question, "Whatever happened to Daddy?", a researcher at Harvard University responded by describing some of the research being conducted there on the role of fathers. It was refreshing to hear, and this book, published by Harvard University Press, is welcome. It is appropriate, perhaps, that the author, also a researcher, is from the University of Illinois, suggesting a widening of concern for fathering in today's society.

Edith H. Grotberg, Ph.D., is Director, Research, Demonstration and Evaluation Division, ACYF.

Divorce Mediation: A Practical Guide for Therapists and Counselors

John M. Haynes, New York, Springer Publishing Co., 1981, 193 pp., $17.95.

Reviewed by Jane Hunsinger

Divorce mediation is a new professional intervention, having emerged only during the past five or six years. Based on the labor mediation process, it is gaining wide appeal because it holds out hope for families in settling disputes over such highly emotional issues as child custody and visitation. While there are divorce mediators in private practice and in family service agencies in many communities, there are at present only a few court-based or court-referral programs providing no-cost or low-cost services.

But the field is rapidly expanding. John Haynes—a pioneer in the development of the divorce mediation theory—has written a guide for therapists and counselors who may wish to move into this field. In his book he explains the mediation concept as applied to divorce and describes the step-by-step process he espouses.

Mediation is neither counseling nor therapy, and many people do not think it should be exclusively in the hands of counselors and therapists. Yet their special skills, training and knowledge about family systems and interpersonal relationships make therapists especially suited to the role of mediator. Haynes sees mediation as an extension of clinical practice with dysfunctional families. As he explains, the helping professional —the therapist or counselor who has been involved with the family during the period leading to divorce—must turn the divorcing couple over to the adversarial system at a time when the special skills of the therapist are most needed. Intervention at this point turns from trying to hold the marriage together to completing the uncoupling process as painlessly as possible. This is especially important when children are involved and their future living arrangements and continuing relationships with parents must be decided on a rational, beneficial basis rather than on a punitive one. Mediation does this by enabling the parties to maintain individual dignity and to control their decisions through a negotiation process in which neither party is demeaned or victimized, and in which neither wins or loses. Mediation fosters a "win-win" outcome, and experience in labor mediation has shown that almost any differences can be settled if each party shares in a positive outcome.

Many court systems have become interested in the mediation method of resolving custody disputes, and the Association of Family Conciliation Courts is taking a lead in introducing mediation services in several state courts.

Dr. Haynes has had experience in the field of labor negotiation and mediation. He is an associate professor at the School of Social Welfare, State University of New York at Stony Brook and, in private practice, is a divorce mediator and director of the Divorce Mediation Project of the Family Service Association of Nassau County, New York. The standards for practice and the mediation model he advocates ensure quality of service. The problem will be to maintain this quality as the public mediation service network develops.

Jane Hunsinger is a Program Analyst, Children's Bureau, ACYF.

Divided Children: A Legal Guide for Divorcing Parents

Michael Wheeler, New York, Norton and Co., Inc. 1980, 224 pp., $10.95.

Reviewed by Teresa E. Levitin

This is an interesting, well-written book that, nonetheless, falls somewhat short of the promise of its title. It presents a number of issues that divorcing parents may need to consider and develops each of these with some social science data, quotes from attorneys or judges, legal precedents, short vignettes and other techniques. The many brief case examples are especially interesting and are nicely used to illustrate the kinds of issues and reasoning often found in custody cases. However, the likely disparity between what divorcing parents may expect and what is (or reasonably could be) presented in a book of this type is troublesome.

Readers may assume from the title that they will be guided step-by-step through their divorces. Although this belief is obviously naive, most people initially have little understanding of the specific legal problems and processes involved in determining the disposition of property, responsibilities for children and provisions for support which accompany divorce. If they

expect this book to be a guide, however inappropriate that expectation, they will be disappointed, for it discusses very generally the issues pertinent to divorce and custody decisions. For example, the chapter on lawyers provides some general advice, proper precautions and examples of questions to be asked in choosing a lawyer. Yet, readers' most pressing questions cannot be addressed in a book: how good is *this* particular lawyer, for instance, and are these charges reasonable for *my* case? Rather, these questions must be answered by the specific facts, needs and circumstances of the family.

The book is strongest in describing legal issues, weakest in using social science data. For example, although the excellent study of M. Hetherington and her colleagues is cited, it is not noted that her sample was limited to preschool children. Research findings are generally introduced to support a point, but the limitations of the studies, the full range of findings and other pertinent data are not provided. Some relevant studies are not included; some studies of lesser quality are presented without adequate recognition of their limitations. The complex problems of research in this area are not taken into account. Consequently, social science data are not used as carefully or as critically as one would hope.

Overall, the book does provide a refreshing and candid look at the role of the legal system in divorce and custody. However, it will be of limited use to those interested in research on divorce and divorcing parents may find it interesting but not specific enough. Lawyers and mental health service providers, however, may be the group for whom the book is most useful, since it suggests some of the fears and concerns divorcing couples bring to them—concerns and fears that both lawyers and mental health professionals need to consider carefully as they attempt to help families through this stressful time.

Teresa E. Levitin, Ph.D., is Executive Secretary, Human Development Study Section, Division of Research Grants, National Institutes of Health.

Divorce Reform: Changing Legal and Social Perspectives
Lynne Carol Halem, New York, The Free Press, 1980, 340 pp., $17.95.

Reviewed by Teresa E. Levitin

This ambitious book attempts to trace the societal meanings Americans have assigned to divorce and their incorporation into legal policy, from the Puritan inauguration of civil marriages to the growing acceptance of no-fault divorce today, an acceptance that has changed both ideas about divorce and divorce laws across the country.

This social-historical study chronicles changes in attitudes toward the causes of divorce, arguing that initial notions of divorce as evidence of moral weakness gave way to notions of social pathology which, in turn, with the growing influence of psychology, particularly Freudian psychology, gave way to notions of individual deviance and psychopathology. The relationships among moral, sociological and psychological perspectives on divorce and the legal system are presented throughout the book. Special emphasis is placed on the role of social and behavioral science data in the formulation, use and modification of legal attitudes, precedents and practices. It is noted that aspects of all three perspectives on divorce presume that divorce is a deviant or pathological condition and that it is remediable. Further, each perspective has its own mandate for legal reform and regulation.

The author, Lynne Carol Halem, does a creditable job in developing each of these points in amassing a substantial amount of evidence for them. The section on Colonial attitudes is the least well developed, primarily because of the limited availability of information. The period between the Civil War and the turn of this century is also given relatively little attention, and, consequently, both the tensions and agreements between the older moral view and the emerging pathological view of divorce are not placed in so rich a social-historical context as one would hope. However, subsequent sections do present a more comprehensive view, and the section on the tensions between fault and no-fault conceptions of divorce is particularly informative.

The chapter on the ways research on family and marital breakdown promulgated a clinical definition of the nature of divorce is also persuasive, although the occasional tendency to use both popular articles and more scientific research as references and (apparently) to give them equal weight is troublesome.

Also troublesome is the author's occasional tendency to oversimplify and to offer sweeping statements without sufficient qualification. This is surprising, since throughout the book she also recognizes the complexity of the topic. Whether commenting on the weaknesses, limitations and contradictions in the research literature or noting the ways in which different perspectives on divorce have been associated with different legal remedies, Dr. Halem evidences a sophisticated understanding of relevant issues.

In sum, this well-written, interesting book should be useful to professionals and laypeople interested in the socio-historical study of divorce law in this country. Despite occasional lapses, the book overall is a carefully documented presentation of the always complex, often unanticipated but always fascinating relationship between the legal system and the changing perspectives on the causes, consequences and responses to marriage and divorce.

Teresa E. Levitin, Ph.D., is Executive Secretary, Human Development Study Section, Division of Research Grants, National Institutes of Health.

Child Maltreatment: A Handbook for Mental Health and Child Care Professionals
Arthur H. Green, New York and London, Jason Aronson, Inc., 1980, 314 pp., $25.00.

Reviewed by Cecelia Sudia

As indicated by the title, this is a handbook for professionals which discusses etiology from several perspectives, including pathological mother-infant attachment, developmental problems

of children, environmental stresses and the special problems of the abusing male. Treatment for children and parents is discussed at length; the major focus is on helping parents become effective and on supporting the whole family. Chapters reviewing research and legal issues are appended but they do not relate to treatment issues. Psychotherapists, particularly those with a psychoanalytic background, will find this a useful volume.

Children in Changing Families: A Study of Adoption and Illegitimacy

Lydia Lambert and Jane Streather, London, The MacMillan Press, Ltd., 1980 and Atlantic Highlands, N.J., Humanities Press, Inc., 1981, 196 pp., $31.25.

Reviewed by Cecelia Sudia

Of the 16,000 children born in England, Scotland and Wales during the first week of March 1958 who were included in the National Children's Bureau longitudinal study, 640 were born out of wedlock and 200 were adopted by parents unrelated to the children. The well-being of these children was studied and reported when they were seven; the current study follows up and reports on their development and progress at age 11.

While the cost of this research monograph is very high, one must be impressed by the quality of the data collection and the careful thought which has guided the analysis. Throughout, the "special status" children are compared with the 12,000 legitimate children who are the main population of the study.

As reflected in the title, the children born illegitimate have experienced greater instability, undergoing changes in their families at a rate three times that of the children born to married parents. One in four children have been in placement as compared to one in 10 of legitimate children. However, the legitimate children tended to come into care after age seven, and for somewhat different reasons.

The children's social class status is related to their birth status, with 86 percent of the legitimate, 95 percent of the adopted and only 50 percent of the illegitimate children living in families in the non-manual worker class. One-third of the illegitimate children were living in poverty, particularly those in one-parent homes. Their housing was poorer, they had fewer amenities (private baths, for example) and fewer families owned their homes.

In regard to school achievement in reading and mathematics, adopted children did best and illegitimate children least well, and these differences are related to social class, number of children in the home and overcrowding. However, on social adjustment, adopted children were lowest, with legitimate children highest.

All in all, while there are many other details, this study tends to reflect the importance of socio-economic status. But the authors also note that while an illegitimate child may gain a second parent early and a more secure life, many of the legitimate children lose parents through death and divorce and also experience instability and insecurity.

Cecelia Sudia is Family Services Specialist, Children's Bureau, ACYF.

Juvenile Delinquents: Psychodynamic Assessment and Hospital Treatment

Richard Marohn, Diane Dalle-Molle, Elaine McCarter and Doris Linn, New York, Brunner/Mazel, 1980, 294 pp., $22.50.

Reviewed by Regis G. McDonald

The authors of this book believe that in order for juvenile delinquents to be helped, methods of treatment used—including individual counseling and the conscious use of the milieu—must be dynamically formulated, based on each youth's unique personality make-up and not solely related to the particular act that caused the youth to be viewed as delinquent. The four authors represent the disciplines of psychiatry, nursing, social work and occupational therapy and they discuss their experiences in developing such a program, one that is psychodynamically oriented and utilizes an interdisciplinary team approach to treat delinquents who require hospitalization because of the severity of their problems.

Established in 1969 at the Illinois State Psychiatric Institute, the program developed treated 55 delinquents, ages 13–17. The adolescents—55 percent males and 45 percent females—came from all socioeconomic groups; the majority (68 percent) were white, 31 percent were black and one percent, Hispanic.

The authors' definition of delinquency includes not only those youths who have been adjudicated but also those adolescents "who have engaged in activities or behaviors contrary to the mores and standards of society, whether these behaviors were known or unknown to authorities." The following presenting problems were noted at the time of hospitalization: rape, truancy, running away, theft, burglary, arson and drug abuse.

The foundation upon which the treatment program is built is one that clearly provides a safe, consistent and emotionally growth-inducing environment for the troubled adolescent. This includes such daily life events as attending ward meetings, going to school, studying and occupational therapy. Individual psychotherapy is focused on the goal of effecting internal change and not merely on having the adolescent accommodate to his treatment environment.

A strong component of the program is the expectation that the youth's families will participate in individual sessions, as well as group meetings. Although all families have not done so, attendance has been much better than one might have speculated, considering the multiple stresses confronting these families.

All readers may not agree with the authors' treatment approaches. However, their book offers an opportunity for those charged with the responsibilities of both caring for and treating the delinquent adolescent to re-think their basic assumptions with respect to dealing with such youths. They make a thoughtful case for quality treatment for delinquents, as opposed to the think-

ing in some quarters that the best thing that could happen to these young people would be for them to be locked away forever.

Regis G. McDonald, A.C.S.W., is director of the Martin Luther King Unit, The Children's Village, Dobbs Ferry, N.Y.

A Is For Aloha

Stephanie Feeney, with photographs by Hella Hammid and designed by Einar Vinje, The University Press of Hawaii, 2840 Kolowalu St., Honolulu, Hawaii 96822, 1980, unpaged, $7.95.

Reviewed by Judith Reed

A is for Aloha, "a word that conveys warm feelings and can be used to say 'hello,' 'goodbye' and 'I love you,'" G is for gecko (a gray lizard) and I is for ipu (a rhythmic instrument made from a gourd) in this exuberant picture book for preschoolers. Author Stephanie Feeney is associate professor of education at the University of Hawaii, where she developed the early childhood education program, and she explains that she wanted to create a book that would show familiar places and objects to which Hawaiian children could relate. At the same time, she wanted to give children in other places "a glimpse of what life is like on our beautiful islands."

The result is a book that all can enjoy—children in Hawaii and elsewhere and parents and teachers who can use it to stimulate children's language development and reading interest. The photographs —all in black and white but far more vivid and spirited than many full color illustrations—show scenes and faces of Hawaii, together with some universal expressions and emotions (D is for Daddy, shown proudly holding his child and Y is for yucky, as eloquently expressed by a preschooler). The brief text includes information on the state of Hawaii, definitions of words and discussion of some of the objects they describe, and useful notes on how adults can share the book with children. Altogether, a delightful, beautifully designed book.

Cushla And Her Books

Dorothy Butler, The Horn Book, Boston, 1980, 128 pp., $12.50.

Reviewed by Mary Lystad

This book is one of the most exciting monographs on child development that I have read. It tells two stories. The first is the story of young parents and their ingenious coping methods with a multiply handicapped child. The second is the story of the role books played in the early development of a child whose world view was severely curtailed by physical infirmity.

The author of the book runs a specialized children's bookshop in Auckland, New Zealand and was awarded a Diploma in Education from the University of Auckland for the study on which this book is based. She is also Cushla's grandmother.

Cushla was born with a kidney defect and breathing difficulties and as an infant she hardly slept. As she grew older, she was unable to focus properly and seemed unaware of people around her. At three months, she was well behind the normal child in most aspects of her development. She was not placed in an institution, however, but remained at home, where she received constant care from her parents.

The child was introduced to books when she was four months old; reading books gave her mother something to do while she held Cushla day and night. When she was tested at 35 weeks, Cushla's language level was only three weeks behind that of the normal child, though in other fields she was considerably retarded. In the next months Cushla's interest in books increased and she began to recognize her favorite words and pictures and for the first time was able to respond to the world around her. By the time she was 18 months old she was beginning to relate events and descriptions in books to real situations, and happenings of her daily life back to books. Testing at age three years, eight months showed an intelligence way above average. She was a happy child, liked by other children, and able to join in many of their games.

The book provides a chronological account (0–6 months, 6–9 months, 9–18 months, 18–36 months, 39–45 months) of Cushla's development, with a particularly strong account of the role of books in her intellectual development. It is of interest for its account of a creative compensatory program for a sensory-deprived child. It is of interest for its description of what kinds of books are useful in conceptualizing a large, complex social order for the very young, whether the child is normal or not. It is of particular importance as a description of the successful collaboration of one small family unit and several large social institutions (including a hospital and other community services).

In the current debate regarding families, social services and social policy, such a description is both valuable and reassuring. This book should be read by specialists in child development, educators, parents of exceptional children and, well, all those interested who care about children.

Mary Lystad, Ph.D., is Chief, The National Center for the Prevention and Control of Rape, National Institute of Mental Health.

Day Treatment *(Continued from page 23)*

day treatment program while living independently. Or, day treatment can be used as an aftercare program or halfway house to phase youths back to their homes or into independence. It can be used for non-delinquent as well as delinquent youth—and with most programs, both can be served together.

Of course, as with any other form of treatment, there are limitations to day treatment and at times it can be frustrating and exhausting to the staff. Our program staff members, however, have been excited about it, and we have been deeply moved by the changes in the young people, particularly since the changes take place partially within the context of their own families. The evidence that the gains continue after the youngsters leave the program is especially gratifying. The fact that youths do not "return" home but continue living in their homes and communities may be a major reason for this.

Our experiences indicate that day treatment is clearly an effective, reasonably efficient service, one that is needed within the spectrum of services available to young people. ■

[1] The day treatment program is funded by an appropriation from the County Board of Commissioners, which receives matching funds from the State Child Care Fund. The COPE alternative education program is funded via purchase of services by public schools, juvenile court and the department of social services.

[2] See, for example, J. Verheex and J.W. Boyd, "Residential Care Through the Looking Glass," Michigan Association for Children's Agencies, Occasional Reports #7, June 1981.

Intellectually Handicapped Mothers *(Continued from page 26)*

mothers, four group sessions were devoted to grooming. All of these interventions were directed at increasing the mothers' ability to interact successfully with adults in their environment.

Outcomes

Over long periods we saw important changes in some of the mothers. In one instance a teenage mother, who had not been feeding her infant regularly and who had alienated clinic staff by not answering their questions and by not attending to the baby in their presence, was made the focus of an intense intervention effort. Gradually, she was able to learn how to cook and feed her baby; she developed skills in talking to clinic staff and obtaining answers to her questions. This young woman entered a job training program, improved her grooming and made friends. Her increased self-esteem was evident when she told us, "My brother and sister say my meatloaf is better than my mother's."

At another time we worked with a couple who at first would not seek medical care for themselves and their children because of their fear of physicians and hospitals. Gradually, they came to trust their worker, who visited them consistently and assisted them in solving problems, and she was able to allay their fears. The couple finally agreed to allow their son to have needed surgery and they were able to visit a local physician and obtain care for their own chronic health problems. Once these changes were accomplished, the couple took steps to improve their housing and income. Moreover, they gained enough confidence to talk with teachers about a problem one of their children was having in school.

Not all families made lasting improvements. After two years of intensive involvement, one young mother still did not realize that her 2½-year-old son could not protect himself from many types of accidents and that she needed to actively safeguard his welfare. At times she left him unsupervised in such potentially perilous situations as the bathtub, while she visited with friends outside their apartment. We eventually arranged a supervised placement for both mother and son, but the mother rejected this plan. Shortly after they moved to an adjoining state. The situation did not improve, and the child has been removed from her custody. There is little likelihood that he will be returned to her care.

At this point, nearly a year after program funding has been terminated, more than half of the families are doing well with no continued services. Some call occasionally but only to tell us news or ask advice. They don't need much assistance. Others require continued support, on a limited basis, through visiting nurses or the local agency serving retarded adults. Four of the families have not been able to improve enough to adequately care for their children and substitute placements—informally with relatives or through public or private agencies—have had to be made.

While mentally retarded parents can have serious difficulties in caring for their children, we have found that, to a large extent, the problems of parents whose intellectual abilities fall into the borderline or mild range of retardation stem more from problems in their own upbringing and living situations than from intellectual deficits.

It is clear that many of these parents can be helped to improve their childrearing skills. What is needed is a mix of services, beginning with casework geared toward reducing their social problems and improving their access to resources. They also require skill training presented in a manner that they can understand. Finally, home visiting designed to monitor their functioning in the home and to follow up skill training activities is necessary.

Services directed to the special learning needs of parents with mental retardation will continue to be needed. In addition to the components described here, programs should offer opportunities for parents to have supervised practice in playing with their children in a preschool setting. Although many of the children in our program did attend child care centers, it was rare that we were able to arrange for their parents to receive supervised practice.

Our society has made a commitment to the rights of the mentally retarded and to maintaining the integrity of families. Such a commitment implies that we must provide the services that are needed to make this goal a reality. ■

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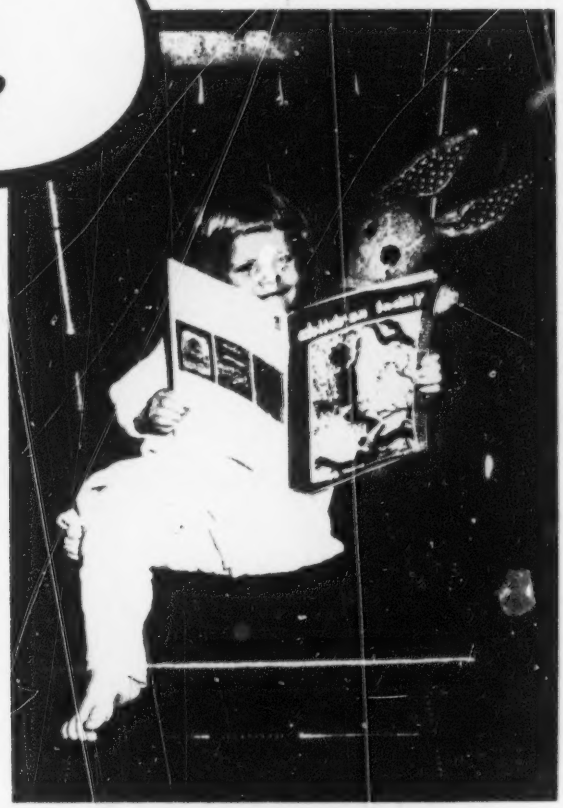

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in this issue

☐ A little more than four years ago we published "Young and Old Together" by Carol Seefeldt, an article reporting on a University of Maryland study of children's attitudes toward the elderly. Many children, the study found, equated being old with being sick, ugly or sad. These negative attitudes were displayed even though most of the children had had little contact with older people; many could not name an older person they knew outside of their own families. Ways in which the isolated generations could be brought together for mutual benefit were also discussed.

Now Dr. Seefeldt, a professor at the Institute of Child Study, University of Maryland, and her coauthors tell us about a new study, this one designed to find out how older people feel toward young children—those under the age of 11. Questionnaires were distributed through 200 Area Agencies on Aging and the responses of a national sample of 1,000 men and women over the age of 65 were tallied. The questions asked fell into three categories: How they felt about children in general, what they knew about them and which activities, if any, they enjoyed performing with them.

The results? Most respondents did have positive attitudes toward children, agreeing, in the authors' words, "that children are to be respected, that they have rights, and that the welfare of children requires national attention." Most also agreed that children are fun to be with and would make good friends for older persons.

On the other hand, many agreed too that children need to be more strictly disciplined. And, not surprisingly, those who had grandchildren and those who saw youngsters frequently displayed the most positive attitudes toward them.

To help those interested in attracting more older people to join the estimated 100,000 who now work with children as volunteers in schools, day care centers, libraries, recreation programs, youth agencies and other organizations, the authors have prepared a guide, *Young and Old Together: A Training Manual for Intergenerational Programs.* Their current article, "How Older People View Children," begins on page 16.

☐ Since 1970, the number of men rearing children alone has nearly doubled. According to the Census Bureau, in 1970 there were 345,000 male householders living with one or more of their own children (under the age of 18) and no wife present. By 1981, the number had increased to 666,000. Of these, 101,000 were widowers, 342,000 were divorced, 74,000 were men who had never married and 149,000 were married men with no wife present in the home.

How such men have adjusted to their solo parenting roles and what help has or has not been available to them and their children have been subjects of discussion in journals and newspapers for some time now. (See, for example, "Single Parent Fathers: A New Study" by Harry F. Keshet and Kristine M. Rosenthal and "Single Parent Fathers: A Research Review" by Benjamin Schlesinger, both in the May-June 1978 issue of CHILDREN TODAY, and "When Father Gets Custody" by Karen W. Bartz and Wayne C. Witcher, in the Sept.-Oct. 1978 issue.) Similarly, scores of articles have appeared on the economic and other problems of mothers raising their children alone. Few, however, have addressed the role or position of mothers without custody, the subject of our Viewpoint feature this issue—see page 12. In it, Janice M. Koehler, who chose to give custody of her then 4-year-old daughter to her husband when their marriage broke up two and a half years ago, shares her feelings and experiences as well as those of some other women similarly situated whom she has met as founder of Offspring, a local support group for non-custodial mothers.

☐ Services to parents who neglect their children and to parents who have referred themselves for help for actual or potential problems of child abuse and neglect are the subjects of two other articles which focus on themes less frequently covered. They begin on pages 6 and 21, respectively.

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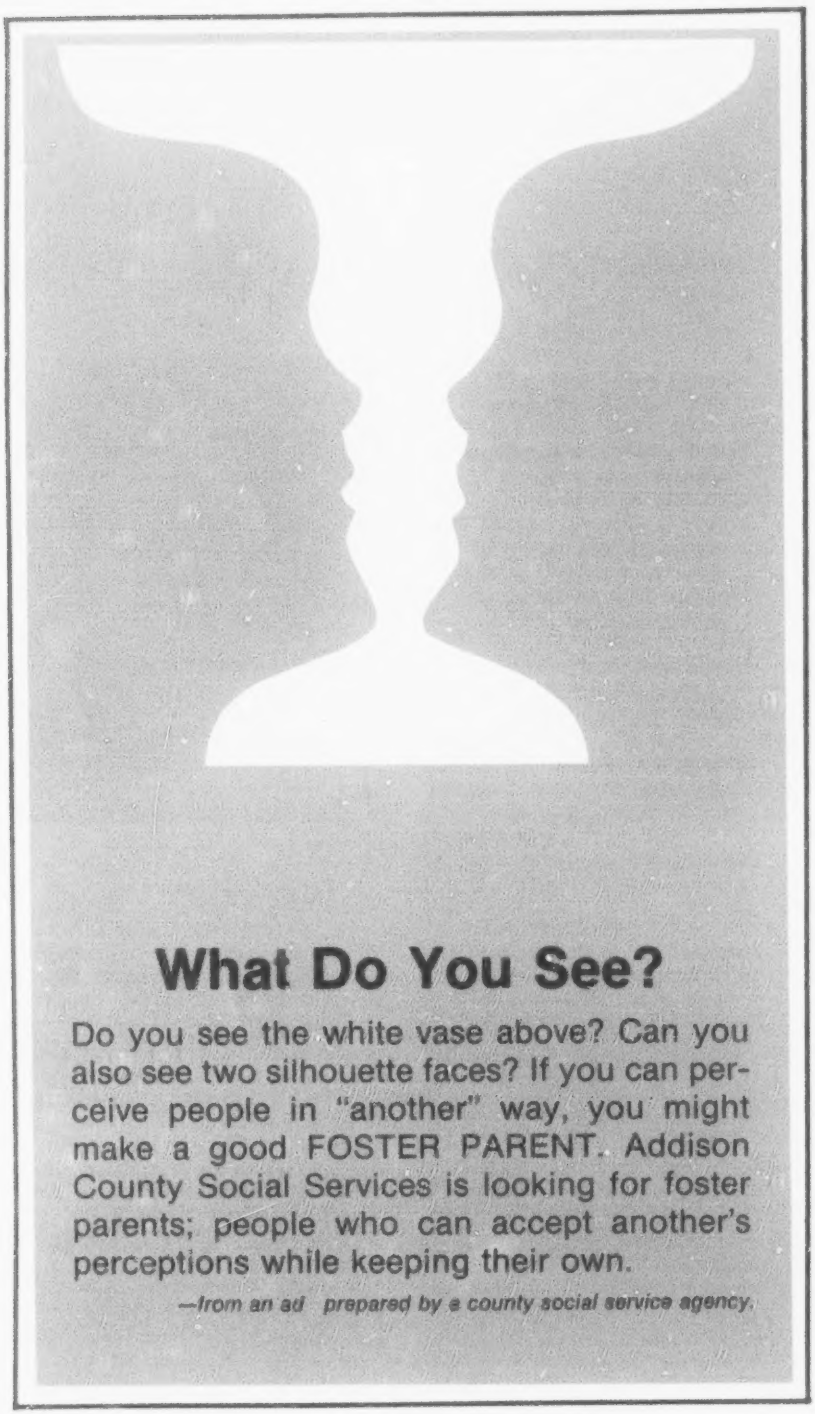
Finding and Keeping

by Eileen Mayers Pasztor and Elyse M. Burgess



What Do You See?

Do you see the white vase above? Can you also see two silhouette faces? If you can perceive people in "another" way, you might make a good FOSTER PARENT. Addison County Social Services is looking for foster parents; people who can accept another's perceptions while keeping their own.

—from an ad prepared by a county social service agency.

In this time of budget cuts and staff shortages for social service programs, there is one available resource in the field of child welfare that can be tapped much more effectively: the foster parent who is recruited, selected and trained to work as a team member with a caseworker to enhance permanency planning for children and adolescents in substitute care. This article describes some policies and practices necessary for agency recruitment efforts to be effective and discusses how foster parents may be encouraged to remain in a program for longer periods of time.

The Recruitment Problem

Twenty-five years ago, the dwindling supply of foster homes in relation to the ever-growing demand for them was discussed in child welfare literature.[1] Today, agencies still indicate a desperate need to locate foster homes, particularly for older children and children with special needs. It has also become increasingly difficult to locate placements for young children and teenagers who are currently in foster homes or institutions that do not meet their specific needs.

Why is there such a shortage of foster homes? Certainly a variety of societal trends have contributed to the shortage. The number of "traditional" families that agencies typically have looked to and recruited as foster parents has declined. More women than ever before are working outside of the home—and working mothers have their own child care problems. In fact, difficulties in arranging child care, particularly for school-age children,

Eileen Mayers Pasztor is a curriculum developer and training consultant for the Foster Parent Project of Nova University, Fort Lauderdale, Florida, and a doctoral candidate in social work at Catholic University, Washington, D.C. Elyse M. Burgess is a curriculum developer and trainer for the Foster Parent Project of Nova University.

More Foster Parents

may be a factor in discouraging working parents from considering becoming foster parents.

In addition, climbing divorce rates, increased mobility, the high cost of housing and the steadily growing number of single parent families and of households composed of single persons or unrelated adults are factors to consider in assessing the availability of foster homes.

Coupled with these external forces, many agency practices also contribute to hampering recruitment endeavors. If staff shortages limit recruitment projects, it is likely that there are also fewer staff members to respond to inquiries or to do a home study and licensing follow-up. Some agencies, for example, report that it can take them as long as six months to review an application and complete the home study. This situation frustrates the potential foster family and raises questions about an agency's credibility in the community after it has advertised an "urgent" need for homes.

Rigid policies may also affect recruitment efforts adversely. Some agencies, for instance, may not permit "flex" or "comp" time for staff members so they can recruit after regular hours; other agencies have fixed standards about foster parents' income and age. Additionally, agencies are not always sensitive to cultural variances—some, for example, may wonder why their all-white professional staff has difficulty recruiting foster homes in their black or Mexican American communities. Individual worker attitudes about troubled adolescents or children with handicapping conditions may also reinforce community fears about fostering.

Finally, perhaps the biggest blocks to successful recruitment—and, subsequently, to successful retention of foster parents—stem from the lack of a clearly defined role for foster parents within the agency, and from the lack of status accorded that role by the agency and the community at large.

Considering that we cannot do much to combat inflation and other social pressures that exacerbate the shortage of foster homes, we need to look at the methods of overcoming recruitment/retention problems that are within our range of competencies to solve. We must begin by redefining the role of the foster parent as that of a valuable agency resource and by viewing the foster parent as a respected member of a children's services team.

Prerequisites For Recruitment

In consulting with numerous child placing agencies around the country (public and private, in both urban and rural areas), one common issue emerged: foster family recruitment is not adequately incorporated into an overall conceptual framework for the delivery of foster care services. Agencies say they are eager to recruit new foster parents. But when we ask, "What is the specific role in your agency that foster parents are recruited to fill?" there doesn't seem to be any agreement.

It is not just that answers differ from agency to agency. Within any one agency, there is considerable disagreement on this issue. For example, the person who licenses foster homes may consider foster parents as team members, somewhat like "non-salaried staff." However, the caseworkers providing ongoing services to children in those homes may perceive their foster parents as clients. The supervisor at the same agency may classify foster parents as they are listed in the *Dictionary of Occupational Titles*—under the same category as butler, valet or other "domestic servant." Foster parents in that same agency may say that they don't have a specific role—other than to be "just a foster parent."

What happens, then, when a foster parent's role within the agency is not clearly defined? The tendency is for foster parents to be caught in a trap of conflicting expectations and agency practices. The trend seems to be to expect foster parents to perform as professionals. They must:

- Handle a wide range of emotional/behavioral problems.
- Be accepting of neglecting and/or abusive parents of children in care.
- Incorporate a new child into their home on short notice and for an indeterminate period of time.
- "Love and let go."
- Work with several different caseworkers simultaneously and with a number of changing workers over a period of time.
- Often perform all of these functions with little or no pre- or inservice training.

Despite these expectations, foster families are simultaneously subjected to such practices as:

- Not receiving complete information about the child in their care.
- Not being allowed input in case decisions affecting children who have been living in their home.
- Not being allowed to meet adoptive parents.
- Having the child in their care "interviewed" outside the home by a worker who does not apprise them of the reason for the talk.
- Not being encouraged or allowed to meet other foster parents.
- Not being regularly reinforced or recognized for a job well done.

To successfully recruit foster parents, agencies first need to develop a consistent and positive approach toward the role they are trying to attract families to fill. Ideally, this role should reflect a teamwork approach. Such an approach should mean that only the child or adolescent in substitute care and his or her birth parents should be considered as clients; it is the responsibility of the caseworker and foster parent to work together to provide a helping relationship to that family unit.

A solid way to begin educating the community about the role of foster parents and to clarify the role of foster parents in the agency is by using job descriptions. A foster parent job des-

cription includes the job title (for example, foster parent, parent counselor, professional parent—whatever is agreed upon by agency and foster parents together); the job objective (for example, helping children and adolescents in your care move toward a permanent home situation); and other categories such as qualifications, responsibilities (to the child or adolescent, the birth parents, the agency), commitment required, supervision, training and rewards or job benefits.

Another prerequisite for successful recruitment is establishing a recruitment theme. This theme must accomplish two goals: it must give a positive message about the role of the foster parent in family and children's services, and it must attempt to attract persons whose interests in fostering are more commensurate with goals of foster care and the intent for permanence. Typical recruitment themes—highlighted only through posters, fliers, etc.—tend not to do either.

For example, picture in your mind a recruitment poster you may have seen recently. Did it show a picture of a young child? Perhaps a young, female child with blond hair who looks rather dejected and pitiful? Did the caption say something about caring and sharing and having room in your home and your heart? Or perhaps you remember a poster showing a teenager with a caption asking you to help this young person stay out of trouble?

These kinds of themes—especially ones that focus on the neglected, younger child—tend to attract people who want or need to rescue kids. Often these people, whose intentions are very good, have real difficulty accepting a child's background, visiting parents or the goal of family reunification. At best, such recruitment techniques reflect false advertising if the message is that "love is all it takes" to be a successful foster parent, or that most children needing homes are in the younger age group.

Instead of selling the child, how about selling a job—foster parenting—that is positive, challenging, rewarding and meaningful? Agencies using this approach are emphasizing such themes as "Foster Parents Are Special People—Like You?" and showing pictures of their foster parents—actual foster parents who are black, white, Hispanic, single, couples, older and younger. Related themes include: "Families Helping Families"; "Foster Parenting: A New Experience in Family Living"; and "Foster Parenting: A Rewarding Job with Meaning, Purpose and Challenge."

Agencies using this approach of selling the *job* instead of the *child* report they are attracting a different kind of foster parent, one whose interests in fostering are more compatible with family reunification and permanency planning efforts.

Once the foster parent's role in the agency has been defined and a commitment has been made to sell the job, the next step is to organize recruitment strategies.

Strategies for Recruitment

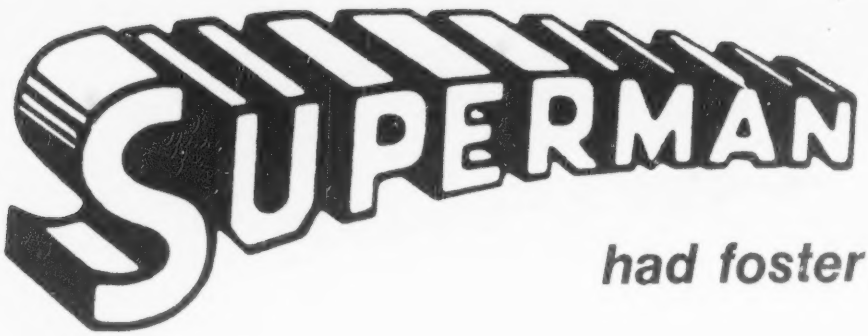
Several important factors that influence successful recruitment efforts should be remembered when planning strategies:

- Recruitment begins with community education. The more knowledgeable a community is about foster care, the larger is the potential foster parent population. The general public seems to be misinformed or uninformed about foster care services and certainly about the significant role foster parents play in the delivery of those services. It is the agency's task to educate the community about the foster care program and to project the role of the foster parents in that program as special and appealing. Here is where total agency commitment to that role is critical: it is awfully hard to sell something that is not widely believed in or accepted.
- Recruitment efforts must be continuous—carried out regularly over a 12-month period. This planning is essential because most foster parents think about fostering for at least a year before deciding to make an inquiry. One-time, blitz campaigns—during Action for Foster Children month, for example—may never reach those who are only in their third or 10th month of personal and family deliberations. (One agency suggested using the theme, "Thought About It Long Enough?")

There are dozens of recruitment techniques that can be used over a 12-month period. Examples are kickoff campaigns, bumper stickers, feature stories in newspapers about parents whose children were in foster care and who were satisfied with the service; public service announcements on radio and television; booths in shopping malls; notices in gas and electric bills; talks at PTA meetings—to name a few. Each method should use the same theme, but no single method is usually successful by itself. People need time to learn about a program, then time to think about it and, finally, to call for information. It has been documented over and over that the best single source of effective recruitment is your existing foster parent population. Use it![2]

- Recruitment efforts must be multifaceted to spark the interest of every member of a family. For example, one agency sponsored a poster contest for elementary school children using the theme, "For a Close Encounter, Try Foster Care." (A group of foster families might give an award for the best poster.) An essay contest can be developed for high school students (for they are potential foster parents). A parent can learn about the special role of foster parents from an article in a company newsletter featuring a foster family with a member who works for that company; the other parent may get a notice about fostering dropped in the grocery bag at the local supermarket. It is important to remember that fostering is not just a mother's task: it is a job for the whole family. Get everyone involved!
- Community involvement is critical. Naturally, there are questions about how an agency can get the staff and financial resources to accomplish recruitment goals. The answer is that help must come from the community. Because the provision of substitute care is a community responsibility, a recruitment committee of community representatives can most effectively carry out the campaign.

Two people are needed to start this process. One is an agency staff member who knows the foster care program and who will be the official agency representative on the committee. The other is an honorary chair-



had foster parents *

person—someone from the community with some prestige, since it is important to convey the high status of being a foster parent. This person only has to lend his or her name to the committee and be invovled in the kickoff campaign. The invitation, however, should come from the agency director. Without the director's sanction and commitment, it will be hard to change the foster care image and follow through with the campaign.

Other people on the recruitment committee should be selectd to fill particular roles. Some individuals with experience in advocacy and community projects—representatives from the League of Women Voters, the PTA or the Junior League, for example—should be included, together with members of the business community with marketing, advertising and media experience and, of course, foster parents and/or representatives from the foster parent association.

It is also important to involve leaders from various community or neighborhood groups—those experienced in working with teenagers and children with handicapping conditions, for example. Fear and lack of knowledge often prevent people from fostering teens or other children with special needs. Meeting those who have had successful experiences as foster parents for such children can help others decide to do so. Finally, some people from other areas of the agency should be included. Every agency-affiliated person is a potential recruiter whether he or she handles payments, brooms, caseloads or switchboards.

Often, recruitment committee members can provide contacts for donations for posters, bumper stickers and other items and expertise on designing the materials. To further emphasize the community involvement, hold committee meetings in the homes of various members or in a meeting room (donated, of course) of a local hotel, bank or restaurant. It cannot be emphasized too strongly that the involvement of the agency director is critical for both starting the committee and giving it ongoing credibility and status.[3]

After an agency has defined the foster parent role, developed an agency-community recruitment committee, identified a theme and outlined a year-round recruitment effort, a plan for retaining foster parents must be established.

Retaining Foster Parents

Foster parents are usually *not* retained for numerous reasons: they are not adequately prepared for the experience; their birth children cannot accept or adjust to an additional child; the marriage cannot tolerate the added financial or emotional stress; more children are placed in the home than the family can cope with at one time; foster parents are not consulted about plans for the child in their care, appropriate information is not shared about a child or adolescent placed with them; they are not taught how to deal with behavior problems or how to work with birth parents; and they are not allowed to participate as part of an agency team. These problems are usually within an agency's control to resolve or at least alleviate by relying on the following practices:

- *The mutual selection process.* Mutual selection is integral to developing mutual trust and a foundation for solid teamwork. It means that a prospective foster family has the right to evaluate, along with the licensing worker, whether or not the agency and family "want to do business together." The agency shares with the prospective foster parents/family all relevant information about the program, including its strengths, limitations, goals and nature of the work required. This is done, for example, through the job description, role playing and individual discussions.

  The prospective family, for its part, is encouraged to share a self-assessment of its ability to handle foster care dynamics, and it reveals what members perceive to be their strengths and limitations in working with children. At the end of this process, both family and worker evaluate each other to determine whether or not fostering is appropriate and, if so, what kind of fostering and for what age children with what kinds of family backgrounds. The most effective way to carry out this process is to build it into a pre-service training program. Agencies using this approach find that it increases successful foster home placements and that many unqualified applicants decide to withdraw from the program prior to licensing, which avoids the discomfort of rejection.[4]

- *Comprehensive foster care education.* Both content and timing are important elements to consider in developing a comprehensive foster care education program. Prospective foster parents have substantially different learning needs than newly licensed foster parents, while experienced foster parents may have an

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* *From a business card carried by foster parents with the Florida Department of Health and Rehabilitative Services in Orlando.*

Working With Neglecting Families

by Marilyn Hall, Angelica DeLaCruz and Peggy Russell

At times all parents experience some guilt over not providing for their children's needs and wants. It may be not buying that extra costume for dance class, or not listening carefully enough to your child's woes while you are busy preparing supper. This is a normal part of parenting. However, there are parents who continually fail to provide for their children's needs, and usually in many ways. These failures eventually affect the child's health and/or development adversely. Characteristically, these parents do not feel guilty over their omissions, and often simply fail to recognize the harmful consequences of the chronic neglected state of their children.

These families are not rare. In 1978 the American Humane Association counted nearly 47,000 substantiated cases of child neglect.[1] These are only the cases that have come to the attention of child protective services agencies. One wonders how many neglected children and their families are distressed and not receiving any help or guidance. The neglecting families who are brought to the attention of human service professionals usually are considered the most difficult to treat. The chronic and severe multiple problems that characterize neglecting families drain agency resources and staff time and energy. Often, agencies hesitate to take on these cases because of the tremendous demands they make and the poor prognosis for change.

Staff members of the Children and Youth Project of the University of Texas Health Science Center at Dallas are acutely aware of the problems involved in treating child neglect and sought to demonstrate a cost-effective treatment of the problem through a demonstration project supported by a grant from the National Center on Child Abuse and Neglect. Project staff members believe it offers an optimal setting to treat these difficult families. Its location, the types of services provided, the method of delivery and the use of a multidisciplinary team approach to care all contribute to maximizing treatment outcomes.

The C & Y Project operates through three clinics located on school grounds in a low-income, public housing area of West Dallas. Two pediatric clinics serve all residents from birth through age 12 and the adolescent clinic serves the 13- to 18-year-old group. Combined, the clinics treat over 12,000 children and youth, providing both health maintenance services and acute care to all registrants.

Health care is a primary need of this population which, prior to the C & Y Project's intervention in 1970, was characterized by high infant mortality, morbidity and hospitalization rates. Such a situation is not unusual in urban settings where there is an area, like West Dallas, populated by families whose income is below poverty level, who often live only by public assistance in substandard, high-density housing and who constitute one of three minority groups (black, Mexican American and Southeast Asian).

Social worker Angelica DeLaCruz talking with neighborhood children.

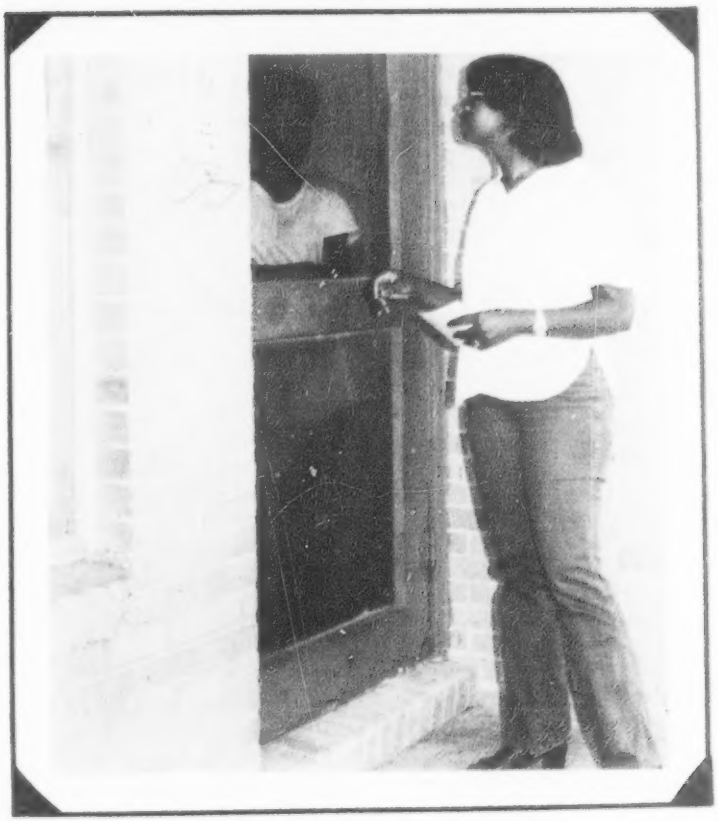
Marilyn Hall is manager of the Child Neglect Project, Children and Youth Project, University of Texas Health Science Center, Dallas. Angelica DeLaCruz and Peggy Russell are social workers with, respectively, the Children and Youth Project's Saldivar Children's Clinic and the Carver Children's Clinic.

Clinic staff members are particularly sensitive to multi-problem families and have developed systems to locate new or non-registrants and to follow up on missed appointments. Staff nurses make visits to the homes of all newborns to identify immediate problems and schedule an appointment to register the family at the clinic. If a registered family misses an appointment, the clinic's social worker visits the home. High risk families (such as neglecting families), who traditionally drop out of service systems, are identified and closely monitored.

The multidisciplinary team approach has been the model used to deliver comprehensive health care to children of the community. Each clinic is staffed with a full-time pediatrician (or adolescent specialist), two pediatric nurse practitioners, one licensed vocational nurse, a social worker and supportive clerical staff. Rotating through the clinics are a psychologist, nutritionist and rehabilitation specialist. An attorney consults on legal issues pertaining to child abuse and neglect cases. Two of the clinics provide comprehensive dental services and the project subcontracts homemaker services from the local Visiting Nurse Association as needed. The multidisciplinary team approach to health care provides multiple resources under one roof and a concentration of staff energies necessary to work with the demands of neglecting families.

The first job of the Child Neglect Project, which began in 1978, was to develop an operational definition of what exactly constitutes child neglect. Staff members perceived neglect to have two main characteristics: It was often a chronic, long-standing problem and it most likely permeated several aspects of a child's life or was so severe in one area it could endanger that life.

With this in mind, project staff members developed an instrument called the Child Neglect Severity Scale that qualifies and quantifies nine categories of child neglect: abandonment, health care, nutrition, supervision, personal hygiene, clothing, shelter, emotional neglect and education.[2] The Scale offers both area subscores and a cumulative score. Several of the nine areas include subcategories which involve a total of 21 items (categories and subcategories included). For example, the category of emotional neglect incorporates the subcategories of stimulation, expectation, nurturance and discipline.



Social worker Peggy Russell making a home visit.

Since the level of care a child receives is not absolute, but rather on a continuum, each category and subcategory is explicity defined according to four levels of care: no problem, mild, moderate and severe neglect. Thus, it is possible to obtain a profile of a family's strengths and weaknesses, as well as a cumulative relative score of the level of neglect. The scale is used in two ways—as a diagnostic tool (to delineate problems and strengths) and as an evaluative tool (to measure change over time).

Neglected children are usually identified in such settings as health facilities, day care centers and schools, or by neighbors. For a number of reasons, a parent will rarely seek help. Neglecting parents (the mother, in our experience) are usually oblivious to the negative effects their omissions have on their children. They often live isolated either physically or emotionally from their extended family and the community. Initially distrustful of intervention efforts, they want to be left alone.

A social worker's first contact with neglecting mothers is usually met with apathy or suspicious but controlled anger. However, once a worker breaks through the initial barriers and establishes a relationship with the mother, he or she finds a scared, frustrated, needy and dependent person who will readily engage with a nonauthoritative and patient individual. Building that trusting relationship is a delicate task.

Intervention

The first step toward engaging a neglecting parent in treatment is to determine a neutral point of intervention. Accomplishing this depends upon the worker's ability to determine what the mother perceives her problem to be, *not* what the health professional or other worker thinks the child's problem is. Telling a neglecting mother that she is not feeding her child correctly, for example, or showing her a declining growth chart only reinforces her poor self-concept and feelings of inadequacy—and makes her withdraw even more from services. However, if the intervention effort is directed first toward the mother and her problems, the effect on the child will eventually be positive. This approach is most effective in situations in which a child's life is not immediately in danger.

This intervention strategy worked effectively with Mrs. Smith, the mother of five children ranging in age from one to 14. A protective services worker had initially contacted the clinic to obtain health services for the children. Visiting the Smith's home, the clinic social worker found the mother and her children, together with Mrs. Smith's brother and father, living in a vermin-infested, 3-room wood frame house with no working utilities. At this time, Mr. Smith was in jail, although he did appear at times during treatment to exacerbate the neglecting situation.

All of the children had major health problems; the diagnosis for the two youngest children was failure to thrive. The children were either not clothed or wore ill-fitting, filthy rags. The two oldest, ages 8 and 14, were not registered in school, and neither the parents nor the school system were successful in getting them to attend.

A variety of emotional and social problems were also prevalent among the children: mental retardation in the 14-year-old; theft and running away in the 8-year-old; the 3-year-old was not toilet trained; and the 2-year-old had no language. The siblings were known to abuse one another physically: their injuries ranged from bite marks to first-degree burns. All of the children lacked social controls and responded to the world in a totally unsocialized way.

The protective services worker felt that he had provided every available service to the family, but he wanted to try a homemaker to see whether the mother could improve the children's physical and nutritional environment. However, the mother had continually refused the offer, saying that she did not need anyone to help her with her house, especially someone who would "spy" on her.

Relationships are built in agency waiting rooms, cars, laundromats and neighborhood grocery stores—wherever a family can be contacted.

With the protective services worker's cooperation, the project social worker approached the mother from a neutral intervention point—the medical clinic—and encouraged her to talk about what disturbed her the most. Much to everyone's surprise, her most distressing concern was to "get protective services off my back"; she thought she could do that if she could only get the two oldest children to go to school. The social worker renewed the offer of homemaker services, explaining to the mother that the homemaker's specific purpose was to come early every morning and help get the children off to school.

Mrs. Smith readily accepted the offer. Gradually, as she began to trust the homemaker and social worker, Mrs. Smith agreed to have the homemaker's time extended to help her in cleaning the house, cooking nutritious meals and managing her children.

Another mother who continually neglected to give her child medication for a major health problem was found, on a home visit, to be living in overcrowded, deplorable conditions and in a conflicting relationship with her husband. The mother's main concern, however, was how she could obtain Christmas presents for her children. Once the social worker was able to acquire gifts from local churches and the Salvation Army, the mother could accept the social worker's visits and gentle approaches to helping her with many other problems.

On another occasion, a social worker making a home visit was greeted by an angry mother who bodily lifted her into the house and proceeded to scream at her about all the personal injustices she had experienced. As the tirade diminished, the worker was able to empathize with the mother's dilemma, which allowed her to express her greatest concern, her obesity. From there, a treatment plan could be devised.

One of the most successful intervention strategies with a neglecting mother is to accept her on her terms and interact with her in her own environment. Relationships are built in agency waiting rooms, cars, laundromats and neighborhood grocery stores—wherever a family can be contacted.

All project workers report a "click" in their relationship with mothers when trust is gained. Sometimes it takes months and repeated home visits; at other times it can occur in a day-long wait at a clinic. However long it takes, once it occurs the social worker knows that the mother is ready to take some serious steps into treatment.

Treatment

Members of each clinic's multidisciplinary team together evaluate each neglecting family to diagnose the multiple problem areas and develop a treatment plan. Once a plan is implemented, it is reviewed at intervals—ranging from weekly to every six months, depending on the problem—to monitor changes and to modify the plan in accordance with the family's changing needs. Resources provided by other community agencies—housing, day care and supplemental food plans, for example—are often needed for neglecting families, and staff members of other agencies involved with the family are also included in the project's case planning.

The case of the Brown family illus-

trates one treatment plan.

Ms. Brown, age 18, and her 4-month-old son were brought to the attention of the neglect project by health clinic staff who had observed several problems: the baby's poor weight gain and feeding problems; the poor personal hygiene of both mother and child; the mother's inappropriate expectations of child development (spanking as a way of disciplining an infant, for example); and unstable residence (mother and child rotated living with parents, friends and relatives).

Under the treatment plan, the Browns were referred to a neighborhood parent-child center, where both mother and child received two prepared meals a day. Additional food was provided by the clinic's WIC program, thus alleviating lack of food as a cause of the baby's low weight. Since the parent-child center also offers supervised instruction and modeling in positive parent-child interaction, workers there assisted the clinic worker in helping to teach the mother appropriate responses to her child's developmental stages and modeled successful feeding techniques—steps toward resolving two other problems.

Since poor hygiene is more often a symptom of a problem rather than a problem itself, project staff members decided not to work directly on that area. Invariably, personal care improves as other problem areas are resolved.

The family living arrangement was a long-range problem involving major difficulties in the mother's interpersonal relationships and self-concept. Ms. Brown was considerably immature and sometimes rebellious. She felt quite alone in the world.

Staff members learned that the best approach with Ms. Brown was the type of gentle, playful back-and-forth bantering that is often effective with young adolescents. In frequent but informal sessions with Ms. Brown—at weekly medical appointments to check her son's progress, for example—the clinic's social worker always made a point of "visiting" with Ms. Brown. The worker discussed whatever the mother was interested in talking about: boyfriends, new clothes, how tough her child was or the unfair treatment she received at home. All talks were low-keyed and nonthreatening and were structured in such a way as to include personal humor and positive remarks concerning any part of the mother's life—her mothering skills, the child's weight gain, personal care, clothes and attendance at the center, for example. Gradually, Ms. Brown began to seek out the social worker for help and advice.

The Brown's case was reviewed monthly for any necessary changes in the treatment plan and progress recorded. After over a year of treatment, the child's weight gain became medically stable and the feeding problem was resolved. The center and clinic staff also noted marked improvement in the mother's interaction with her child, especially in disciplining him. She also displayed a more mature approach to life by being able to solve problems, follow instructions and meet appointments. Her personal hygiene improved dramatically and her residence stabilized.

Social worker Angelica DeLaCruz helping a mother fill out an application.

After a family's situation has stabilized, the case is reviewed every six months. Cases are not terminated—all children cared for by the clinics are on the caseload until they are 18 years old or move out of the target area.

Outcome

Successful outcome with a neglecting family is difficult to determine. Is terminating parental rights and placing children for adoption considered a successful outcome? Or is success a mother who now sends her child to school regularly but continues to live in filthy, hazardous and chaotic surroundings? Should all parents be expected to provide a minimally acceptable standard of child care, or are slow, successive approximations toward that level considered adequate? If so, what is the minimum acceptable level and how long should the parents be allowed to work to attain it—while the child's time clock ticks away?

These are some of the questions that are of primary concern to the project. Staff members feel strongly that all cases must be objectively evaluated, rather than have outcomes based purely on subjective viewpoints or personal values. This objective evaluation is being done with 40 test families every six months during the 3-year period of the grant. The evaluation is reviewed from the child's perspective, since a child has no control or defense against parents' continued omissions of care.

Outcome evaluations can be either global ratings from a knowledgeable group with respect to the previously delineated problem areas, or outcome can be measured using objective tests or tools. The project, in conjunction with measures in the medical charts (growth charts, hematocrit), uses eight tools to evaluate outcomes. One such measure is examining videotaped sequences of the mother interacting with her child. Unbiased raters score these tapes behaviorally, looking at any changes in the quality and quantity of the interaction over time. Other areas being measured include the child's behavior; the social worker's perception of the mother; the mother's personality characteristics; the mother's outlook on life; the child's perception of life; the child's locus of control; and the child's intelligence.

Data collected over the 3-year period are now being analyzed and results will be available later this year.

(Continued on page 36)

YOUTH GANGS

A Look At The Numbers

by Walter Miller

Given the extensive participation of law-violating youth groups in serious criminal activity in the United States, it would seem that accurate information on their numbers, membership and the proportion of youth who belong to such groups would be an essential element of any policy aimed at preventing, controlling or reducing crime. Yet no such information has ever been compiled. The collected data and estimates reported here represent the first known set of figures on the number of law-violating youth groups and group members in the United States.*

A major source of information was on-site interviews conducted in 26 localities with 458 persons from juvenile and criminal justice agencies, private and public social service agencies and schools. Among those interviewed were former youth gang members. In addition, telephone interviews to obtain information on the presence or absence of problems with youth gangs were conducted in these localities and approximately 50 others. Newspaper reports of youth gang activities throughout the country, gathered through a clipping service, also provided important information. Routine police reports, academic literature and documents issued by federal agencies were also reviewed.

The figures indicate that there are approximately 120,000 law-violating youth groups with about 1.5 million members in the 2,100 American cities and towns of 10,000 population and over. The number of group members is equivalent to about one-fifth of the number of adolescent males in these communities. While representing as comprehensive a presentation of the number of law-violating youth groups as is currently available, these figures are still incomplete—that is, they do not include figures on a number of highly prevalent groups such as larceny cliques, burglary rings and robbery bands.

These summary figures combine data for two categories of groups—gangs and disruptive local groups. Both are sub-types of "law-violating youth groups," defined as an association of three or more youths whose members engage recurrently in illegal activities with the cooperation and/or moral support of their companions. A *gang* is defined as a self-formed association of peers, united by mutual interests with identifiable leadership and internal organization, who act collectively or as individuals to achieve specific purposes including the conduct of illegal activity and control of a particular territory, facility or enterprise. A *disruptive local group* is defined as a regularly associating group or clique usually identified with a geographic entity (for example, housing project, street corner or park) or facility (a store or poolroom, for instance) and whose customary behavioral repertoire includes illegal activities such as drinking, drugs, disorder, vandalism and petty theft.

There are about 2,200 gangs with 96,000 members located in approximately 300 United States cities and towns. Gangs comprise about two percent of the number of tabulated law-violating youth groups, and gang members about seven percent of all group members. Although the number of gangs is small in relation to the number of non-gang groups, the number of gang members is approximately twice the total number of juveniles confined in all types of detention and correctional facilities, and the number of cities with gang problems is more than 10 times the number commonly recognized.

Gangs are disproportionately concentrated in the largest cities. The 10 largest cities with gang problems—New York, Chicago, Los Angeles, Philadelphia, Detroit, San Diego, San Antonio, Phoenix, San Francisco and Boston—with about 18 percent of the population of all cities of 10,000 and over, contain just about half of the nation's gangs, and two-thirds of its gang members. However, of the approximately 300 U.S. cities with gangs, the number found in the 10 largest is roughly proportional to their population (53 percent of the population, 51 percent of the gangs). This means that about half of all gangs, and about one-third of all gang members, are found in cities with populations of one-half million or less. These figures support earlier findings that indicate an increasing probability of finding gangs in cities of smaller size than has traditionally been the case.

Unexpectedly, the relationship between the size of the city and its numbers of gangs and gang members is not a simple one. Examining the statistical association between city size and various measures related to the number of gangs in the 10 largest cities (for example, numbers of gangs and gang members; gangs/gang members per capita; average number of gangs per city; average size of

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Walter Miller, Ph.D., an anthropologist, conducted the National Survey of Collective Youth Crime at the Center for Criminal Justice, Harvard Law School. His article is adapted with permission from Change: A Juvenile Justice Quarterly *(Vol. V, No. 1, 1981), published by the National Office for Social Responsibility under a grant from the Office of Juvenile Justice and Delinquency Prevention.*

gangs; gang members as a percent of the male adolescent population) shows good statistical association between city size and raw numbers—that is, larger cities have larger numbers of gangs and gang members. There is also good association between city size and average gang size; gangs are larger in larger cities. *However*, the statistical association between city size and gang members per capita is poor. When the size of cities is taken into account, the strong associations found in the case of raw numbers disappear. It appears that the "density" of gang members in particular cities—that is, the number of members per unit population—has little relation to city size. The propensity of local youth to form gangs is different in different cities, and this propensity is related to factors other than the size of the city.

Extending an examination of the relation between city size and the number of gangs and gang members to the 285 cities with gang problems shows the situation to be similar in most but not all respects to that of the largest cities. As in the case of the largest cities, the statistical association between city size and the numbers of gangs and gang members is good and the association between size and per capita rates is poor. Dividing the cities into five categories based on size and location, however, shows that numbers of gangs and gang members are not directly proportionate to category populations. For example, numbers of gangs, but not gang members, are disproportionately high in the largest cities. Numbers of both gangs and gang members are disproportionately high in smaller California cities, and disproportionately low in smaller cities outside of California.

Despite the fact that problems posed by law-violating youth groups other than gangs are far more prevalent than gang problems and judged by many to be equally or more serious, even less information is available on their numbers and membership than is available for gangs. A nationwide enumeration of one of the most prevalent types of group—disruptive local groups—is based on data collected in 13 cities reporting group problems. These are Dallas, San Antonio, Milwaukee, Cleveland, Boston, St. Louis, Denver, Pittsburgh, Minneapolis, Newark, Ft. Worth, Miami and St. Paul. These cities have a combined population of 6.9 million, and range in size from 290,000 to 800,000. Data based on reports by local respondents indicate that there are 9,200 disruptive local groups with a total membership of 107,000 in the 13 cities. The average city contains about 700 such groups and 8,250 group members. The number of group members for all 13 cities is equivalent to 17 percent of the male youth (aged 10-19) population. Percentages range from a low of three percent (Denver) to a high of 42 percent (Boston).

In contrast with the situation reported for gangs—a strong relation between city size and numbers but a weak relation between size and per capita rates—neither numbers nor rates show any significant association with city size in the case of groups. Nor is there a significant association between city size and the size of the average group. The number of adolescent males in these cities is also poorly associated with measures of the numbers of gangs and gang members. These findings were quite unexpected, since it would seem reasonable to suppose that there would be more groups and/or larger groups in cities with larger numbers of youths.

Data collected in 13 cities, along with additional data obtained less systematically for about 60 additional communities, provide the basis for estimates of the total number of disruptive local groups and group members in the 2,100 U.S. cities and towns with a population of 10,000 or more. These figures indicate the existence of approximately 116,000 disruptive local groups with 1.4 million members in the cities of the United States. The number of group members is equivalent to about 18 percent of the male youth population of these cities.

It should be borne in mind that an evaluation of the seriousness of collective youth crime problems involves more than numbers alone. Since gangs are disproportionately concentrated in the largest cities, their activities are more likely to receive wider publicity and to arouse higher levels of public concern. In addition, the kinds of illegal activity engaged in by gangs are generally much more serious than those engaged in by the average non-gang group. This raises the issue of whether a very large volume of minor crime poses a greater or lesser crime problem than a smaller volume of more serious crime.

It should also be noted that while the number of gangs and gang members tabulated here may seem small when compared to the number of groups and group members, current data indicate that gangs are far more widespread than previously supposed. The presence of gangs in almost 300 cities—13 percent of all U.S. cities of 10,000 and over—and the activity in these cities of about 2,200 gangs with 96,000 members, indicate that violence and other forms of illegal activity by youth gangs in the United States continue to pose a major crime problem. ■

The study reported here, Crime By Youth Gangs and Groups in the United States, was funded by the National Institute for Juvenile Justice and Delinquency Prevention, Office of Juvenile Justice and Delinquency Prevention, U.S. Department of Justice. A final report on the study will be published later this year by the National Institute for Juvenile Justice and Delinquency Prevention.

Viewpoint:

Mothers Without Custody

by Janice M. Koehler

It's haunting to be a mother without custody. It colors my existence; it leaves me feeling breathless sometimes and vulnerable. Non-custodial mothering is not the role choice I had in mind years ago. I had pictured myself a happily married wife and mother of two, living a suburban lifestyle and teaching my children's friends in the neighborhood school system. The American Dream that I envisioned is not the one I am living.

Sometimes there is little comfort in knowing that I chose my non-custodial status. Even though I allowed my daughter's father to have primary custody, there is no surcease of pain in missing her day-to-day growth and experiences. Bandaging the scraped knee, carrying the small shoes to the closet, tying the colored yarn around the ponytail, listening to her read—I miss all these aspects of my lost role.

My decision to allow Jordan's father primary custody two and a half years ago, when Jordan was 4, came after many hard decision-making months. Fortunately, Jordan's father and I had realized that, to avert disaster, we would not use our child as a weapon against one another. Our marriage had deteriorated to the point that one of us had to leave.

Jordan's father had always been adamant in his opinions regarding custodial settlements. He had always insisted that no one would take his child, and he continued to be adamant regarding custody of Jordan. Since he had always shared the responsibility of child care and was a nurturing father, my insistence on being the primary custodial parent might result in, at the worst, Jordan's kidnapping or, at best, a horrendous custodial battle in court. After considering these alternatives, together with other factors bearing on them, including a serious health problem on my part, I chose to give the custody of Jordan to her father.

The hardest questions to answer about most mothers without custody are who they are and why they choose to be non-custodial. In my networking efforts as founder of Offsprings, a support group for non-custodial mothers (see accompanying box), I have talked to many women. Although their experiences vary, mothers without custody generally fall into two groups: those who have lost custody battles and those who choose not to fight for custody.

Women who lose custody battles seem to continue the fight, some even to the point of kidnapping their children. Mothers who fight for the custody of their children seem to feel, in many cases, that the children are critical to their identity. These women have been "raised to be mothers," to believe that "children belong to the mothers." Having custody of their children gives them a reason to continue with their lives. (It is interesting to note that several women who have been battling for custody have ex-spouses who take nurturing and generous care of their children.)

One mother, desperate after fighting in the courts of two states for more than a year, was literally at her wits' end when she called to talk with me. She had no job and was paying both living and legal expenses out of an inheritance. Although she had been trying to straighten out her life enough to find and hold a job, nothing had seemed to jell for her until her children were sent back to her by court decision. After she had received custody, she found a job and no longer felt the need to participate in Offspring.

These fighting women, who are often desperate and in emotional need when they call Offspring, seldom remain as members when they regain custody so it is difficult to ascertain much about their lives and why they need their children so desperately in order to survive.

Janice M. Koehler is founder of Offspring, a support group for non-custodial mothers in the Washington, D.C., area. *©Janice M. Koehler 1982.*

The second group of women without custody are those who choose, in varying ways, not to have custody. I have been discovering that those who "choose" must include those who have let events overtake them—custodial choices that are not made actively but passively. These women include those who leave their husbands and children for another relationship. Sometimes these women are told by their spouses that the children will remain in the family home. The woman, guilty because she has done something that is not socially acceptable, leaves the children in the father's custody. Clearly a choice has been made, although it was a passive one. The woman has chosen the new relationship rather than not to have custody. Furthermore, she has an excuse for yielding custody, one that society will accept, although it may not condone her choice.

Another kind of passive choice occurs when women who began their separations *with* custody of the children, or assuming that they would want and receive custody, are overtaken by events. They allow the children to live with the father or grandparents for long periods of time without making a final decision about custody. Many of these women are in new environments: a new career, school or community in another state. Often the external demands made upon them by their new lifestyles are burdensome to the point that the children are left with the grandparents or fathers at the end of visitation periods.

Many of these women desire to have custody of their children when their lives become more regularized and stable. However, such women have not actively made their choice—events have. And sometimes it is easier to push aside the need for decisions, to never regularize and stabilize one's life because to do so would force one to look squarely at the custodial question.

Women who actively choose not to have custody of their children are at a vanguard in our society. They are on the cutting edge of a society that declares motherhood a prime function and duty of women. The women whom I know who chose to be non-custodial mothers did so not because they did not want or like their children

Support Groups

Offspring provides a referral service and support network for non-custodial mothers; non-custodial fathers are also welcome to participate. Monthly meetings feature presentations and discussions on such topics as dealing with anger, visitation, child support and the non-custodial mother's role in society. Additional information may be obtained by writing to Offspring, P.O. Box 23074, Washington, D.C. 20024.

Nationally, Parents Without Partners, with 1,100 local chapters, welcomes both mothers and fathers without custody. Many of the local chapters—listed in the telephone directory—offer programs and services to meet the specific needs of non-custodial parents, or can refer parents to appropriate community agencies.

The Family Service Association of America, with 260 affiliate agencies in the United States and Canada, provides counseling and, in many agencies, advocacy and self-help groups for single and non-custodial parents. Information on community social service programs may be obtained from local affiliates (listed in the telephone directory) or from Family Service Association of America, 44 E. 23rd St., New York, N.Y. 10010. ■

but because they recognized that their being the custodial parent would not be the best circumstance for their children. There were many reasons for their decisions. One mother decided not to continue her fight for custody five minutes before the court hearing was scheduled to begin because she feared the damage that would be done to her children when the many intimate details of her family life were aired in the courtroom of the small Catholic town in which she lived. Another woman realized that she needed time and energy for her beginning career, as well as to clear her confusion; hence her three children live with their father.

Several other women I spoke with were overwhelmed by what they had felt was demanded of them as mothers and wives, both by their families and society, and so they did not choose custody when their marriages broke up. For other mothers, the choices had seemed more clearcut; they realized that their teenage sons wanted to live with their father.

Other factors, although not of primary consideration, are also important to consider when one is deciding on custodial arrangements. For instance, women still earn 59¢ for every $1 that men earn in similar positions.[1] Society's continued discrimination against women cripples our ability to support the family unit without a husband's income.

Other statistics merit a careful look, as well. "Many wives," says Emily M. Brown, director of the Divorce and Marital Stress Clinic in Arlington, Virginia, "feel that settlement is a 'rip-off.'" For example, statistics show that only 49 percent of mothers with custody receive the full amount of child support payments.[2]

Women who have been full-time wives and mothers face a difficult job market when they begin looking for a job that will compensate them adequately enough to support a family. This was true in my case, for even though I had a good education, my career prospects were limited when I stepped away from the economic security of my marriage. My only professional experience had been in teaching, a skill not recognized as having much worth in private industry.

In considering custody, I felt limited in ways that Jordan's father was not. Although career choices for women are changing, women have been traditionally consigned to semi-skilled, clerical and other kinds of routine jobs. Even though approximately 60 percent of the nation's women are working, only 25 percent of them are in management positions.[3] Many women have the increased burden of trying to get ahead, of needing to continually prove themselves on the job, while also trying to make ends meet as a single parent.

Only 49 percent of mothers with custody receive the full amount of child support payments.

In my case, my particular marketability problems were compounded by a serious kidney condition. In view of my lack of health and uncertain career prospects, I felt I had little choice in the matter of my child's immediate custody. Because Jordan's father clearly loves her and is a good parent, I relinquished my hold and opted to rebuild my life.

Like other mothers without custody of their offspring, I was then caught in a web spun by feelings of guilt and unworthiness. As I began to reach out and make friends, I found other women like me. Because mothers without custody are just now beginning to receive public attention, little research has been done on the subject; yet the viewpoint of mothers without custody is particularly interesting. In attempting to make some sense of my situation, I began talking with other mothers without custody. Three of them agreed to talk about themselves for this article, and I also spoke with two social workers involved with such mothers.

The first woman I interviewed is in her late 30s. When I asked her what some of her reasons were for yielding custody of her five children, she paused thoughtfully.

"When I say them aloud, my motives are not lofty. It would be nice to say that I needed to go to school or had to get my career established, but that was not the case." She explained that her five children had been born within six years. Her husband had traveled on business, taking time for skiing trips and sight-seeing vacations while she was at home raising the children. With the ending of her marriage, she felt that she had to give up the responsibility of raising the children for a while. At the time, she could not separate the resentment she felt for her husband from the feelings that she had for her children.

"Women are beginning to have society's permission to leave their children with the father," says Emily Brown. "Women find that they cannot economically afford the children while attempting to rebuild or start careers."

Another counselor, a staff member of a social work counseling service, Tobler and Milne Associates, Ltd., in Vienna, Virginia, says:

"Other factors influencing women in their decision to give custody to their husbands, based on the women I have seen in my practice, include a woman's reaction to the breakdown of the marriage and her assumption of over-responsibility for it. Her low self-esteem at this time may also lead her to doubt her ability to mother well. Or she may wish to avoid a custody battle to protect the children from further hurt, and to rebuild her relationship with her children later. Some mothers without custody may come to accept the fact that they are not interested in, or capable of, full-time mothering."

Adjustment for mothers who choose not to have custody is as difficult as it is for men who are not custodial parents. Like men, women tend to feel themselves adrift after the separation, to feel that their new surroundings are not really a home. The pieces of borrowed or newly-bought furniture haven't the smell, texture or feeling of being lived in, on or around. There seems to be no cohesion in one's surroundings and no continuity between the often "good" vibes at work and the "bad" vibes from an empty apartment or, as many of us perceive it at first, from life. But of course, life is not the empty space; the emptiness is within

us. And so we learn to fill it, perhaps crudely at first. Many women plunge into work or school. The second woman I interviewed had plunged into both.

This woman had left her husband eight years ago. Not having worked outside the home for 16 years she had foreseen a difficult adjustment. Three facts influenced her initial thoughts about custody: she had to take care of herself; she had no money; and she had no place to live. While coping with a tremendous sense of loss, she finally found a place to live by promising to refurbish a couple's basement. She got a part-time job and enrolled in school to complete course work for her college degree. Now, four years later, she has completed her degree and is working full time.

"There are not enough low-cost mental health or legal services for women who choose to leave their husbands," she says. "And it is essential to have support groups for both non-custodial fathers and mothers."

Many mothers without custody, like non-custodial fathers, actively reach out to build a social network. However, the stigma and guilt of being a non-custodial parent are much greater for a mother than for a father. Social attitudes are changing but the change is a slow process. Generally, I have found that those who are most threatened by change are the most abusive when they find one to be a non-custodial mother by choice. Somehow, it's honorable to be a victim of circumstance and not have custody of your children but once you have actively chosen to be a non-custodial mother, the honor of your choice vanishes.

Last fall I appeared on a television program, *Up to the Minute* with Harry Reasoner. Another guest was a former child psychiatrist who expressed the opinion that women who left their families had some sort of "psychological problem" and that "if she would get help she would mature and not leave home." A kindly, 50-plus, clean-cut gentlemen, he called me "dear" and was obviously uncomfortable whenever he had to look at me for apparently I didn't fit his definition of the kind of woman who would leave home. However, I doubt that he rethought his position.

Strangely enough, I have found that those people who seem to be most certain about how they would react in a custody situation are middle-aged or older men who are at least financially comfortable, if not very successful, or women who are protected by having married successful men.

I had the opportunity of observing such women when I was a guest on the Phil Donahue Show in Valley Forge, Pennsylvania, last spring and they formed part of the audience. Mr. Donahue asked questions regarding my non-custodial status and the audience was encouraged to respond and continue the questioning. The theme of "careers" was picked up by one member of the audience who accused me of putting my career ahead of my child. "Why did I have a child if I wanted a career?" she asked. My reply was that I had made a choice to have both. Mr. Donahue, a custodial father, answered neatly. "Why is it different for a woman to have a career and child when men have both?" Afterwards, members of the audience came to speak with me. At least 10 to 15 women and two men understood my position, recognized the difficulty of my decision and wished me luck.

The stigma and guilt of being a non-custodial parent are much greater for a mother than for a father.

My experiences within the social fabric of Washington, D.C., where I have continued to live and where I now work, have been mixed. At one social function, an older man—a non-custodial father—asked where my daughter and I lived. After I told him that my daughter lived with her father, he asked if I were some kind of "party girl." I responded that I was no more a "party girl" than he was a "party boy."

Often women who learn of my non-custodial status tell me that they wish that their ex-husbands had wanted custody of the children for at least a while. Others say that although their ex-husbands wanted custody, they had felt that acceding to the wish wouldn't have been the thing to do. They speak sadly of wasted years when they and their children were unhappy.

Custodial fathers often say that they understand their ex-wives' decisions to leave the children with them. In some cases, these men have encouraged their ex-spouses to build their careers and to find themselves. Custodial fathers enjoy their role despite all the difficulties that single parenting brings. Many would not consider allowing the mother custody again.

Non-custodial fathers are interested in my feelings for my daughter and can see that men and women share the same feelings about their children. Their response when I tell them the reasons that I relinquished custody has been one of empathetic understanding.

Among the most hurtful questions that I have been asked are those that came from my daughter's friends—children she meets when she lives with me during vacations—"Are you really Jordan's mother?" and "Why does she live with her father if you are her mother?"

However, the stigma a non-custodial mother bears is less in a large city than in a small one. And Emily Brown has found that a greater majority of mothers consenting to give custody of the children to the father are from the middle and upper classes.

The third woman I interviewed had sought counseling before she left her family. Jane had felt exhausted by the demands of being expected to manage and coordinate the schedules of three other lives, working to build her own career and studying for an advanced degree, as well as housekeeping. "The job became overwhelming," she said. "I felt that I needed time to be alone, to do something for myself for a while."

She felt that the expectations placed on her by society and her family had left her, after 14 years of marriage, with no room to breathe. This mother of two daughters, now aged 12 and 8, also feels the need to find a support group among other mothers without

(Continued on page 35)

How Older People

by Carol Seefeldt, Sue Bredekamp, Richard K. Jantz and Kathy Serock

Photo: ACTION

An RSVP volunteer, a former high school teacher, works on a beautification project.

An aging population and a declining birth rate are both factors in contemporary American life. So too is increasing age segregation.

Many older persons live in housing developments for senior citizens or in other areas with few young families. Children often live far away from their grandparents, and many children cannot name an older person they know outside of their family.[1]

This segregation is often reflected in the social attitudes of the older generation. Separated physically and socially from young children, the elderly may find it easy to dismiss the needs of children. Turning inward, toward their own unmet needs, older people increase the separation between young and old. It is easy to vote against a school bond issue or funding for day care or youth recreation programs, for example, if you or your children or grandchildren will never use these neighborhood facilities and you do not know any children in the area.

Limited contact between children and their elders also leads to fewer, mutually enriching opportunities to share affection and it further negates the development of positive attitudes between the old and young generations. We do know that the younger generation very often perceives the elderly in negative ways.[2] For example, many children claim that old people are unattractive and sickly, and when asked to say how they would spend time with them, children name only passive activites.[3] Some children say they don't ever want to be with

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Carol Seefeldt, Ph.D., is Professor, Institute for Child Study, and Richard K. Jantz is Associate Professor, Curriculum and Instruction, University of Maryland, College Park. Sue Bredekamp and Kathy Serock were Research Associates at the University of Maryland.

10/A '82

View Children

older people and that they never want to become old themsleves.

And what do older people think about children? Do they really like, want to be with and do things with children? Do they really "just love" little children?

In order to find out just how older people felt about children, a nationwide sample of about 1,000 persons, all over the age of 65, was asked to respond to questionnaires designed to assess attitudes toward children.[4] The questionnaires were distributed through 200 of the approximately 600 Area Agencies on Aging. Altogether, 2,000 questionnaires were mailed and 1,000 completed responses returned.

The majority of those who responded were parents or grandparents. About 44 percent of the respondents lived in cities; 27 percent were in rural areas and 20 percent lived in the suburbs. Ten lived on Indian reservations. There were more women than men in the sample; the great majority—86 percent—were white. (Ten percent were black and the remainder, Hispanic, Asian and Native American.) Most respondents had completed high school and 21 percent reported at least some college. Over 75 percent said they were in good health and a majority reported interacting with young children at least several times a month.

The questions were designed to measure attitudes toward children under the age of 11. Since much of the research on children's attitudes toward the elderly had been conducted with children under the age of 11, it was decided, in turn, to ask the elderly how they felt about children of the same age.

Three different types of questions were asked. One set of questions was concerned with finding out how older persons felt about children, while another was designed to indicate what they knew about them. A third group of questions sought to identify those activities they enjoyed with children. All of the questions were developed around the idea that attitudes are not composed solely of feelings but are also rooted in what we know about the object, and how we behave toward it.

How do Elders Feel?

As it turned out, most of the older people did feel positively about young children. They described children as "innocent," "eager to learn" and "curious and inquisitive." One respondent called children the "hope of our future" while another characterized them as "the joy in our life."

Twenty statements, such as "Children ask too many questions," "Children appreciate what they have," "Children cheat more than adults." and "Children are fun to do things with," were given, and respondents were asked to indicate their level of agreement or disagreement with these observations.

In general, they agreed that children are to be respected, that they have rights, and that the welfare of children requires national attention. The majority believed that adults should earn a child's respect, not just expect it; that children are fun to do things with and would make good friends for old people; and that children's opinions should be valued. The ideas that children deserved privacy and that they do not cheat more than adults were also expressed.

There were, however, aspects of children and their behaviors that the elders felt negatively about. The older people usually indicated that children need to be more strictly disciplined, and they judged some behavioral

Photo: ACTION

In Staunton, Va., an RSVP volunteer drives youngsters to the community child care center.

characteristics of children objectionable. For instance, they thought that children were demanding and that those who receive a lot of attention turn out to be spoiled, and they believed that children should not question their parents. The elders also felt that adults should never give in to a child and that children "deserve what they get" when they are bad. Some also expressed ideas that children were undependable, that they need to be told what to do most of the time, and that there's a time and place for children.

Feelings toward children were complex, however, and differences in how elders felt about children, based on their own education and experience, were found. For example, the responses indicated that the more education an elderly person had, the more positively he or she felt about children. Those who had completed college, or had some college, felt more positively about children than those who had not attended college. Those who had grandchildren under age 11 also had more positive attitudes toward children. Attitudes toward children seemed related to the background of the elders.

And, not surprisingly, the responses revealed that the more frequently a person interacted with children, the more positive were his or her feelings toward all children. Those who did not have grandchildren of their own, or who had limited contact with young children (interacting with children less than once a year) felt more negatively about them.

Sex, age, health and where the person lived were also related to feelings about young children. Women felt more positively than men about some aspects of children—for example, women more often agreed that children's opinions should be valued and more frequently disagreed that children who receive a lot of attention turn out to be spoiled. Men, on the other hand, agreed more frequently than women with the statement that children appreciate what they have, and they more often disagreed that adults should never give in to a child.

Elderly persons in good health, as compared with those who considered their health to be poor or fair, more often disagreed that children need to be told what to do most of the time. The older respondents (those over the age of 70) tended to agree more frequently with the statements that children are fun to do things with and children would make good friends for old people. Those between 60 and 70, however, saw children as less demanding and troublesome than those over 70.

It was interesting to learn that people who lived in cities, as compared with those living in rural areas, agreed to a greater extent that the welfare of children requires national attention. The responses also indicated that people who lived in rural areas, compared with those living in the suburbs, believed children need to be told what to do more of the time.

What Do Elders Know About Children

In this set of questions, respondents were asked to indicate when most children could complete specific tasks, such as speaking in simple sentences, writing a sentence or reading.

In general, those questioned did know a lot about children. Over half answered 73 percent of the questions correctly. They did, however, have more accurate expectations for older children—those between the ages of eight and 11—than for younger children. When they made mistakes, they usually overestimated what tasks children could perform at a specific age. For instance, the elders thought that children would be able to do such

The study found that older people enjoy playing cards and board games with children.

things as walk, talk or catch a ball later than they usually learn to do them.

As in the responses to the section on feelings, differences in knowlege of children were found to be related to sex, education and experience. Women had greater knowledge than men of children in the youngest age group, and those who had attained the highest educational levels indicated that they knew more about children. And, of course, the more frequently the elders had contact with children, the more accurate was their knowledge of them.

Activities With Children

In this section of the questionnaire, respondents were asked to describe what they did with children under the age of 11 and to indicate which age group they preferred.

A few of the older people surveyed said they didn't want to do anything with children under the age of 11. "I've never enjoyed being with children when I was young, why should I want to be with children now?" one commented. But most of the elders identified a number of different types of activities that they would enjoy with children. Most of these were passive in nature—the most frequently named were playing table games like Monopoly or cards, reading to or talking with children and watching TV.

Children were viewed as good companions for outings to zoos, sporting events, museums and concerts, and for shopping and camping trips. Several respondents mentioned that they really enjoyed being with children and taking them places because children were always so eager to learn and they, the elders, had much to teach.

Active pursuits with children were not mentioned by many respondents. Fewer than a dozen said that they enjoyed playing ball, bowling, swimming or dancing with children. Taking walks together, however, was an enjoyable activity for a majority.

Most of the older people said they would prefer to be with older children, at least those over age five. They said that children over five were still young and easily satisfied but "not smart alecky yet." "They aren't babies anymore," one explained. "You can do things with them, but they're not disobedient." More than a few people added that they really preferred the company of girls because girls, they said, are "nicer, sweeter and better behaved than boys."

Conclusions

The results of this study indicate that the negative attitudes children express toward age and the elderly are not reciprocal. What seemed to emerge was a picture of elders who value children, respect their rights and enjoy their company—as long as they could be with children on their own terms. They did strongly agree that "there was a time and place for children" and when questioned further, it was clear that this time and place should be controlled by them, the adults.

It may be that the elderly in our nation really do "just love children." An estimated 100,000 older people now work as volunteers with children in schools, day care centers, libraries, recreation programs, museums, youth organizations, community agencies and other settings. To encourage more older people to act upon their positive attitudes toward children, and to foster positive attitudes between generations, however, systematic and deliberate plans to bring young and old together may be required.

If RSVP, ACTION and Foster Grandparents programs are not present in a community, for example, recruitment efforts can be employed. Surveying neighborhoods to identify older people who might be interested in working with children; talking about such a project at churches, shopping centers or social gatherings; advertising in local newspapers or on radio—all are effective methods for attracting older volunteers.

Photo: ACTION

Top: Foster Grandparent and child. Bottom: At the age of 96 this RSVP volunteer was reading to children in a Mississippi Head Start Center. Now, six years after the picture was taken, he no longer visits the center—but his son serves as a volunteer there.

Photo: ACTION

As the results of this study indicate, education and knowledge about children are highly related to positive attitudes toward children. These findings support the need for training programs to provide elderly volunteers with accurate information and knowledge about children, including techniques for teaching and disciplining them.[5] Program organizers should also make an effort to match older people with children in the age group with which they feel most comfortable.

Perhaps planned interactions between young and old will lead to the reestablishment of more caring relations between the generations. Both children and the elderly could benefit from increased contact. The lives of many older people might be enriched and the oldest generations might begin to act on their positive attitudes toward children by supporting programs for them. Children, coming in contact with fulfilled, successful, active older people, would have to challenge their ideas of age as something to be feared. Certainly the quality of life for both generations could be enhanced through increased contact between the generations. ■

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[1] R. K. Jantz, C. Seefeldt, A. Galper and K. Serock, *Children's Attitudes Toward the Elderly: Final Report*, College Park, Md., University of Maryland, 1976.

[2] See T. Hickey and R.A. Kalish, "Young People's Perceptions of Adults," *Journal of Gerontology, 23*, 1968; D.G. McTavish, "Perceptions of Old Age: A Review of Research Methodologies and Findings," *Gerontologist, 11*, 1971; and E. C. Thomas and K. Yamamoto, "Attitudes Toward Age: An Exploration in School Age Children," *International Journal of Aging and Human Development, 6*, 1975.

[3] C. Seefeldt, R. K. Jantz, A. Galper and K. Serock, *Children's Attitudes Toward the Elderly: A Study of Curriculum Implementation: Final Report*, College Park, Md., University of Maryland, 1977.

[4] The study of Elderly Persons' Attitudes Toward Children was funded by the American Association of Retired Persons/National Retired Teachers' Association, ANDRUS Foundation, and supported by the Computer Science Center of the University of Maryland.

[5] As a result of this study, the authors have prepared a training guide entitled *Young and Old Together: A Training Manual for Intergenerational Programs*. Copies may be ordered from the ERIC Clearinghouse, Early Childhood Education.

Clients Who Refer Themselves to Child Protective Services

by Diane DePanfilis

The Voluntary Intervention and Treatment Program in Erie, Pennsylvania, is one of five projects funded by the National Center on Child Abuse and Neglect (NCCAN) to demonstrate ways in which public child protective services agencies can incorporate programs to encourage and manage voluntary self referrals by parents with actual or potential problems of child abuse and neglect. From the experiences of several NCCAN projects, it is clear that such programs can increase the number of families that request assistance and improve treatment prognosis through early intervention and by tailoring the type and management of services to suit the needs of self-referred clients.

Motivation and self-awareness are important elements in any effort to change behavior, and both public and private agencies are seeking ways to build upon the motivation demonstrated by families who voluntarily seek their help. Many public child protection agencies, while accustomed to assuming a high degree of involuntary intervention in response to third-party reports of child abuse and neglect, are uncertain as to how to handle self referrals sensitively. Private agencies are equally concerned about referring their voluntary clients to a mandated and sometimes impersonal system of reporting, investigation and protection. These demonstration projects have combined efforts to maximize the willingness of families to request assistance, and they have developed careful techniques to insure that children receive protecton and that families are provided with effective services.

This article focuses on the methods used by the Erie project to develop a self-referral program and some early and encouraging results.

Diane DePanfilis directed the Voluntary Intervention and Treatment Program, Children's Services of Erie County, Erie, Pa.

History and Objectives

The Voluntary Intervention and Treatment Program (VITP) operates within the Child Protective Services Unit of Children's Services of Erie County. The philosophy of Children's Services embraces a helping or treatment approach, rather than a punitive one. This is demonstrated by the infrequent necessity for court action in working with the majority of families referred to the agency for child abuse/neglect problems. An average of 70 to 75 percent of the 600 families included in the caseloads of protective services are involved with caseworkers on a voluntary basis.

Also of significance is the fact that the Pennsylvania Child Protective Services Law of 1975 (P.L. 438, Act 124) has a clear treatment and rehabilitative focus: it designates the CPS agency as the single agency mandated to receive reports of child abuse/neglect and further protects the client's right to confidentiality by requiring that reports made to CPS *not* be released by the CPS to law enforcement agencies. Although a client's confidentiality would be protected, the law does provide for release of information pursuant to a court order. As a result, if a report were made to the police by another source, information from CPS could be court-ordered to be released. Although this was not expected to occur with any degree of frequency, project staff members negotiated an agreement with the District Attorney whereby the DA agreed to consider suspending criminal prosecution where the client had self-referred to VITP *and* was agreeing to continue in treatment.

Futhermore, a Pennsylvania Department of Public Welfare Child Protective Services Regulation states that among their services for the prevention and treatment of child abuse and neglect, CPS agencies shall establish "groups organized by former abusing parents to encourage self-reporting and self-treating of present or potential abusers."

A basic premise of VITP was that

most abusive parents want to be helped to change their abusive behavior and that some of these parents have the insight and motivation to be able to identify the need for treatment. With this philosophy, VITP set out to develop a program that would concentrate on encouraging self referrals and on responding to them with a helping approach. We believed that the number of parents wanting to seek help would increase when they realized that their request would be met with a non-punitive response.

The overall objective was to develop a specialized treatment plan for self-referred parents, one that would involve them in case planning and use peer community support systems. The approach used to achieve this objective included the following components:

- *Development of a non-threatening public awareness approach to reach parents.* The theme, "It's Not Easy To Be A Parent," was selected because its earlier use by The Family Stress Center in San Diego had been successful in increasing the number of self referrals to that program. We developed pamphlets and posters around this general theme and distributed them initially to other professionals who were likely to identify "at risk" families. Pamphlets were also left in waiting rooms of offices frequented by parents and information about VITP was included in the child abuse public awareness presentations offered by Children's Services to numerous general public and professional community groups.

The number of self referrals increased significantly after initial public awareness efforts and have continued on a consistent basis.

- *The establishment of staffing patterns that made immediate response to parents possible upon their first contact with the project, regardless of the level of presenting problems.* The full-time staff consists of two caseworkers and one parent aide, with a supervisor and project director working part time on the VITP project. In addition, a CPS caseworker has been designated to work with self referrals as the rate of referrals has increased beyond the capacity of the two caseworkers.

A schedule was established to ensure availability of a caseworker or the supervisor during regular working hours, and arrangements were made with Protective Services Intake to receive self referrals after regular hours. Training was also provided to after-hours staff, enabling the agency to respond on a 24-hour basis to both new self referrals and emergencies with current project clients. Thus, a worker is available to assist a client in resolving any precipitating crisis and to immediately involve a parent with the project at a time when he or she recognizes the need for help. This method also allows for the same type of response whether a parent is expressing a fear of losing control or reporting an actual abuse situation.

- *The establishment of an intensive assessment period that involves the client in examining all factors that may be contributing to the abuse or neglect potential.* An elaborate outline was developed for use by the project worker to involve the client in assessing the family situation through an individual interview and by completing a non-threatening questionnaire. In addition to giving the worker and client a good basis from which to develop a treatment plan, the assessment process allows for the building of a positive caseworker-client relationship.

Due to the intensive involvement expected, and the fact that workers are expected to cover intake as well as ongoing caseloads, each caseload is limited to a maximum of 15 families at any one time. As the number of self referrals exceeds the maximum, additional CPS staff are designated to work with self referrals.

- *Client involvement in the establishment of a time-limited treatment contract.* Since the "authority" of protective services can by its very nature suggest a threat to the parent, the use of a treatment contract is considered to be an effective tool in relieving some of these fears. The contract also helps to maintain the parents' motivation by involving them as much as possible in establishing and reviewing treatment goals.

The usual length of a contract is six months. If parents achieve their goals within that period, they can terminate their involvement with VITP services, but they are invited to attend monthly parent meetings and to call if further help is needed. For parents whose problems are not resolved, the contract can be renegotiated. The reduced length of treatment, then, has continued to make smaller, more manageable caseloads possible.

- *Focus on individual treatment for each family.* A carefully individualized treatment plan, focusing on responding to those needs identified by the parent, is developed. Services offered include individual counseling for all appropriate family members, including the children; marital, family and/or group counseling; and traditional child welfare services such as emergency financial assistance, day care and homemaker services.

The services of a parent aide are also available for socially isolated families. The parent aide becomes an advocate for the parent, providing support in a variety of ways. The aide may babysit to relieve the mother, establish a friendship with a child who needs special attention, provide transportation to necessary appointments, or take the whole family on an outing.

In addition, peer support is offered through monthly parent meetings that provide opportunities for socialization and information about community services. A parent education group, based on the Systematic Training for Effective Parenting (STEP) model, also meets weekly for nine weeks.

The project worker also refers parents to other community agencies and coordinates services with them.

Parents Who Refer Themselves

Parents who have contacted VITP come from all socioeconomic backgrounds. Only 45 percent of the families are receiving some type of public assistance. Although the majority of the calls (93 percent) have been from mothers, treatment services have been provided to 37 two-parent families—52 percent of all families served. Eighty-nine percent of the families have been white—a figure that corresponds to the total Erie County population (1980 census) of 90 percent caucasion and 10 percent black and other minorities. Most parents (70 percent)

TABLE I
Primary Problem Identified By Client At Time Of VITP Intake

PROBLEM TYPE	NUMBER EXPRESSING PROBLEM	% OF TOTAL FAMILIES
A. Physical Abuse		
1) Actual	24	33.8%
2) Potential	36	50.7%
		Sub-Total 84.5% Physical Abuse
B. Sexual Abuse		
1) Actual	0	.0%
2) Potential	0	.0%
C. Emotional Abuse		
1) Actual	0	.0%
2) Potential	2	2.8%
D. Neglect		
1) Supervision	0	.0%
2) Nutrition	1	1.4%
3) Medical	1	1.4%
4) Instability of Home Environment	4	5.6%
5) Home Conditions	0	.0%
6) Marital Discord, Alcohol, Drug, Mental Health Problems of the Parents Negatively Affecting Parental Care	1	1.4%
7) Lack of Parenting Skills	1	1.4%
8) Emotional Needs of Child	1	1.4%
Total Referrals	71	100%
		46.4% Admitting *Actual* Physical Abuse + Neglect

have completed high school and 25 percent have also had some college or vocational training.

Who are these parents?

Ruth, the mother of a 3-year-old daughter and a year-old son, was feeling overwhelmed trying to manage her children. She said that she screamed at her daughter and found herself kicking and throwing the child. Ruth has received individual counseling and she and her husband are undergoing marriage counseling. Ruth attends VITP monthly parent informational meetings and has attended the parent education classes, during which time transportation and babysitting were provided. Her daughter was enrolled in a day care program for abused children, which gave Ruth some relief from child care and some time to herself.

Ruth has identified the abuse she received as a child as a factor in her abuse of her daughter. She has worked very hard and enthusiastically on her problems and has decreased significantly the abuse to her daughter. Ruth is still working on improving her life and feels very proud and relieved. She has also referred a friend to VITP and given a brochure on it to another friend.

* * *

Marian, a single mother of a 4-year-old girl, called VITP because she was screaming at her daughter so much that the girl had begun to cower away from her. Marian felt her own abusive background and past poor relationships with men were affecting her current functioning with others as well as with her daughter. Through individual counseling and by attending the monthly parent meetings, she began to feel better about herself and her role as a parent. With her new confidence in herself, she was able to become involved in taking a sign language course. Not only did she learn a new skill which she hopes to use with friends who are deaf, but Marian also met new friends and improved her ways of interacting with people.

* * *

Stephanie, the mother of a 3-year-old son, called VITP after being informed of the program by a friend who was involved in it. Stephanie found herself often screaming at her son and sometimes slapping him, and feeling terribly guilty afterwards. She attended the parent education classes and monthly parent meetings and also received individual counseling. Stephanie came to realize that the stress of her extremely poor marital relationship had led her to lash out at her son. Stephanie's husband has refused to be involved in the program, but she has learned better ways of dealing with her son and has worked on finding other ways of releasing her frustrations.

* * *

Donna, a young, inexperienced mother with a year-old son, was overwhelmed by trying to provide for herself and her son on her public assistance income. She had no transportation and few people she could call upon to babysit if she needed to go out. Donna took her frustrations out on the baby by shaking him. When the

VITP parent aide began to take Donna to her medical appointments and to watch the baby for her, some of her frustrations lessened. With most of the basic physical needs taken care of, Donna now has more energy to work towards resolving her own emotional problems.

* * *

Most of the parents who have contacted the project have revealed a history of physical abuse or a fear of losing control and becoming physically abusive. Table I indicates the specific problems indentified by the parents at the time of their initial self referral to VITP (not necessarily what the worker would assess to be the problems). Actual physical abuse was recorded if the parents' past actions had resulted in physical injury to the child, if they expressed a past history of "losing control" while administering corporal punishment, or indicated other types of physical assaults.

Of significance is the fact that 75 percent of the clients were not receiving services from Children's Services (the mandated CPS agency) at the time that they were identifying actual or serious potential for abuse/neglect. Of further significance is the fact that 48 percent had never had contact with Children's Services of Erie County.

Initial Results

During the first year and a half, 71 families had referred themselves to VITP. Forty-nine families, or 69 percent, have engaged in treatment services with project staff beyond the intake evaluation. Comparing the 21 percent opening rate for CSEC protective services vs. the 69 percent rate for parental self-referrals clearly illustrates the efficiency associated with reaching parents who are correctly identifying abuse potential. The basis for case opening in all instances is the presence of a "risk" for child abuse and/or neglect. The original objectives for the families in treatment included five goals: prevention of child placement; prevention of court involvement; decreased length of time in treatment; increased effectiveness of treatment; and prevention of further abuse/neglect.

Among the approximate 156 children and their families receiving services through VITP, there has been only one known incident of child abuse/neglect during treatment. There has not been a need to refer any case to CPS or court and evaluations of clients at termination have shown an improved ability to provide adequate parental care. The average length of service among the families actually terminated from VITP is 8.8 months versus the Children's Services Protective Services average of 22.3 months in treatment.

Project services have been focused toward family unity, as there has not been a need to place any child in long-term care. (Five children have benefited from temporary foster care placement of less than 30 days due to family emergencies.) The use of homemaker, day care and parent aide support services have contributed toward preventing the need for longer-term foster care. Table II compares treatment outcome among cases opened in VITP and in agency protective services.

Although it would be inappropriate to state that the types of problems identified by project clients are the same as those clients receiving service within the protective services unit, we believe that the seriousness of problems is comparable. The types of problems identified by project clients demonstrate a higher incidence of physical abuse, while those identified in clients receiving protective services demonstrate a higher incidence of physical neglect and sexual abuse. (See Table III.)

TABLE II
Treatment Outcome, A Comparison of Cases Opened

Type of Referral	Placement Rate	Mean Length of Placement	Mean Length of Treatment	Use of Court
Parental self referrals (VITP) N=98 children	5% (5)	17 days	8.8 months (14 families)	0
System Identified (Protective Services) N=545 children	26% (142)	398 days	22.3 months (N=153 families)	19% (103)

Community Involvement

A strong focus of the project has been to use existing community support services. Bringing VITP to the attention of approximately 100 social service agencies has been effective in encouraging self referrals. Use of volunteers for child care and transportation was arranged through two existing volunteer agencies. One of the organizations draws solely upon senior citizens, who have proven to be particularly reliable and committed.

A local primary prevention agency provided training (at no cost to the project) to casework staff in the STEP parent skills program. A written agreement with the YWCA has provided space for parent groups—and the YWCA offered membership scholarships to project clients. Contact with an interfaith clergy organization resulted in space being provided for a boys' support group in a local church equipped with a gymnasium.

The project parent aide has developed a monthly list of family social activities available in the community and has obtained free passes to the

zoo for project clients. In addition, project clients have had the opportunity to attend a locally sponsored communication skills workshop and have been exposed to a variety of presentations by other professionals at the monthly educational support meetings.

The project supervisor serves on the Child Abuse Council's education committee, which assists the agency in providing public awareness and community education presentations on the subject of child abuse and neglect. The project supervisor works to ensure that the local community climate will continue to be responsive to parents seeking help.

Use of college students as volunteers and in structured field placements has expanded the quantity of services available and has exposed social work students to a different aspect of public child welfare.

Conclusions

Project staff members believe that VITP has successfuly achieved its initial objectives by encouraging 71 parents to refer themselves (49 are continuing in service); during the same year, approximately 200 families became involved with protective services through outside reports. The effectiveness of services with these families is demonstrated by the fact that only one known incident of child abuse/neglect has occurred during treatment, compared to a 14 percent recidivism rate for CSEC protective services. Counseling services and parent aide support, combined with traditional child welfare support services, have successfully reduced the risk of abuse/neglect and prevented the need for child placement.

Considering the extensive public awareness campaigns to encourage third-party reports, we strongly believe that as much time and effort should be spent to encourage parents to self refer. Attracting parents who have already abused their children results in better potential for successful treatment. Parents who have been reported for abuse have appropriate fears about prosecution and having the child removed from their care, and they often express hostility and resistance during initial intervention. Extensive time is required to develop a trusting relationship before treatment can be effective.

If a parent already recognizes a problem, his or her motivation can be maintained by continuing to involve the parent in the treatment process. If the length of service can be reduced, and the need for court intervention prevented, the CPS agency can begin to address more cost effective methods of prevention and treatment.

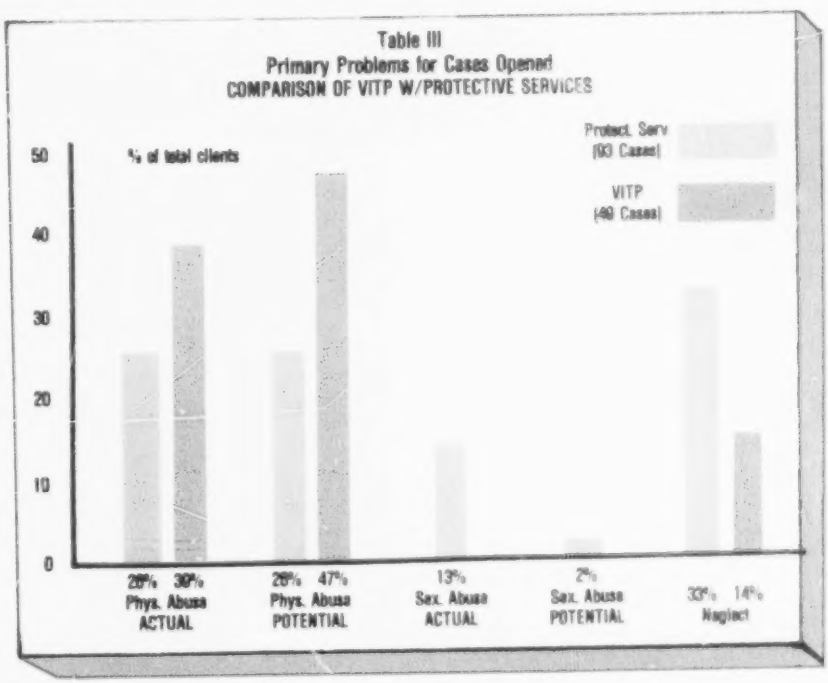
In addition, reaching parents who self refer before an actual abuse incident occurs further prevents the need for more expensive, "after the fact" services. Based on our experiences with families who asked for help prior to committing abuse, we believe that these parents were appropriately identifying themselves as "at risk." Our initial case assessments have shown few differences (in relation to family dynamics and stress factors) between those parents who referred themselves prior to an actual abuse incident and those who had previously harmed their children.

Replicating The Project

We believe that every public child protective services program should seriously consider ways to encourage self referrals. Any program, of course, must be tailored to fit the individual community. Considerations prior to developing a program would include the general climate of the community, negative barriers within the system and the availability of non-threatening quality services. How the child protection system is perceived by the community is important. If it would be difficult for a parent to ask for help due to mandatory procedures within the system, it might be necessary first to consider developing flexible mechanisms which would reduce the level of fear experienced by parents in need of services.

As the child protective service agency in our community, we believe we have an obligation to provide prevention and treatment services in a helping, non-punitive manner whenever possible. Based on the success of this project with self-referred clients, we have instituted similar methods with other voluntary clients and have made the decision to continue our efforts with self referrals beyond the time limits of the demonstration grant.

We believe our results are not all that surprising; working with clients who are motivated *should* result in better success in treatment. Since our efforts substantiate this, we believe more time should be spent by CPS agencies to encourage parents to refer themselves. ■



NEWS & REPORTS

The Fatherhood Project

The Fatherhood Project, an effort to determine how men can become more active in childrearing, has been launched at Bank Street College, New York City. Currently, the project is working to identify programs and projects that support men in nurturing roles, establish a clearinghouse and prepare a guide to innovative programs and resources across the country. Research is also being conducted on employment policies, divorce laws and other areas that affect men's involvement with children.

In addition, the Project offers "Oh, Boy! Babies!," a "hands-on" course in infant care for 10- to 12-year-old boys and girls at the Bank Street School, and "For Fathers Only," a weekend group for fathers and toddlers.

Supported in part by grants from the Ford, Levi Strauss and Ittleson Foundations and the Rockefeller Family Fund, the project is directed by James A. Levine, author of *Who Will Raise the Children? New Options for Fathers (and Mothers)*. Co-directors are Dr. Michael Lamb, professor of psychology, psychiatry and pediatrics at the University of Utah, and Dr. Joseph Pleck, director of the Program on Family and Work at the Wellesley College Center for Research on Women.

Additional information may be obtained from The Fatherhood Project, Bank Street College of Education, 610 W. 112th St., New York, N.Y. 10025. The project also welcomes information on and referrals to employment, legal, educational, health, social services, mental health, and religious programs with a focus on fathers—particularly fathers from low-income and minority groups.

Using Volunteers

The effective use of volunteers by social service agencies can not only strengthen agency services but also lead to additional sources of funding, concluded panelists participating in a forum on "Funding Volunteer Services—Potential Sources of Dollars to Expand Agency Programs." Proceedings of the 1980 forum, which was sponsored by the Federation of Protestant Welfare Agencies, New York City, have now been published, with updated information, in a 24-page booklet of the same title.

Trends in financing volunteer services are discussed by representatives from a business corporation, a social service agency, a foundation and the National Center for Citizen Involvement. The booklet also contains the panelists' responses to questions from the audience on such subjects as using volunteers for direct service, locating volunteers and obtaining information on grants for volunteer services.

Single copies of *Funding Volunteer Services* may be obtained at $3.50 each from the Department for Volunteer Program Services, Federation of Protestant Welfare Agencies, 281 Park Ave. South, New York, N.Y. 10010.

For Subscribers

The cost of a subscription to CHILDREN TODAY, including the annual index, is now $11.00 domestic, $13.75 foreign. The single copy price is $2.75 domestic, $3.45 foreign.

The $120,000 Child

The cost of raising a child from birth to age 18 could be as high as $120,500—or as low as $29,700, according to updated estimates prepared by the U.S. Department of Agriculture. *USDA Estimates of the Cost of Raising a Child: A Guide to Their Use and Interpretation* breaks costs down into raising children in urban and rural nonfarm areas and on farms, and by levels of expenditure consistent with USDA food plans. Estimates are given in constant June 1980 dollars.

For urban and rural nonfarm children, the levels of expenditure are defined as economy, low and moderate while for farm children, the levels are thrifty, low, moderate and liberal. The $120,500 estimate applies to raising a farm child at a liberal level of expenditure; the lowest figure—$29,700—is for raising a rural nonfarm child at an economy level. Among other estimates:

- $69,200 to $76,700 to raise an urban child at the moderate level (depending upon the region of the country).
- $52,400 to raise a farm child at the low level.
- $43,400 to $55,600 to raise a rural nonfarm child at the low level, and $64,600 to $79,900 at the moderate level (depending upon region).

The estimates reflect a child's share of family expenditures for eight items in the budget: food at home, food away from home, clo-

thing, housing, medical care, education, transportation and "other." USDA economist Carolyn S. Edwards, who prepared the report, notes that the estimates emphasize direct costs, or out-of-pocket expenses, and do not represent the total costs of raising a child. For example, college tuition and such indirect costs as the value of services performed by family members or earnings lost because of childrearing are among the expenditures not included.

Single copies of the 57-page report (Pub. No. 1411) may be obtained free from the Office of Governmental and Public Affairs, U.S. Department of Agriculture, Washington, D.C. 20250.

Working With Young Adolescents

School personnel, youth group leaders and other professionals who work with young adolescents—those in the 10- to 15-year-old age group—will find three new resources of particular interest:

New Roles for Early Adolescents, published by the National Commission on Resources for Youth, Inc., focuses on youth participation in school and community programs. Prepared by Joan Schine, director of the Commission's Early Adolescent Project, the 48-page booklet discusses characteristics of youngsters aged 10-14; provides examples of youth participation in community service, peer teaching, internship and other programs; and offers suggestions for implementing youth participation programs and working with community resource people.

Single copies are available at $5.00 each from the National Commission on Resources for Youth, 36 W. 44th St., Rm. 1314, New York, N.Y. 10036.

Schools for Young Adolescents: Adapting the Early Childhood Model is the third in a series of monographs by the Center for Early Adolescence, University of North Carolina at Chapel Hill, for those who work with 10- to 15-year-olds. Author Stephanie Feeney, Ph.D., associate professor at the University of Hawaii, discusses similarities in development between young children and young adolescents and ways in which an early childhood perspective can be applied to educational programs for young adolescents.

Single copies of the 39-page monograph, which also contains an annotated bibliograpny on early adolescence, may be ordered at $2.75 each from the Center for Early Adolescence, Suite 223, Carr Mill Mall, Carrboro, N.C. 27510.

Early Adolescence: A Resource Directory, also published by the Center for Early Adolescence, lists organizations, periodicals and bibliographies in such subject areas as advocacy, community services, education, health, parenting and youth participation. The resource directory is available at $2.00 per copy (plus 50 cents for postage and handling) from the Center for Early Adolescence.

"I gained 155 lbs. and I never felt better in my life."
—Jack Walden
Everybody knows that foster families are good for homeless kids. They get care and love, food and shelter, guidance and so much more.
But did you ever stop to think of how much it helps the families who take these kids in?
Families all around Rhode Island are experiencing the special gains that come when they take in foster kids. Both teenagers and youngsters. The joy. The satisfaction. The genuine heart-felt pleasure of helping kids when they need it most.
You can't buy those kind of rewards for a million dollars. But they're there for the taking, simply when you sign up for Foster Family Care. We've got foster teens and kids of all ages, all races, from all social-economic backgrounds. Some from broken homes. Some from homes with illness or death. Some very normal, healthy kids. Some with special problems. Some need an overnight stay. Some need a home for weeks, or months. But they all come with one guarantee. You'll gain a few pounds of kid and a whole lot more.
If you'd like to know more, call us at 277-3797. Rhode Island Foster Family Care, Department for Children and their Families. The gains are enormous for the kids and for you.
Foster teens. 277-3797. The gains are enormous.

A WINNING CAMPAIGN. This ad prepared for the statewide foster parent recruitment campaign conducted by Rhode Island's Department of Children and Their Families (DCF) and the Rhode Island Advertising Club won first place in the state's annual "Supershow" competition for public service advertising. Altogether, 13 advertising agencies and communications organizations are cooperating in the campaign, with Richard M. Tavone, recruitment supervisor for DCF, serving as creative and technical consultant.

Home Day Care Training

Two sets of curriculum materials for use in training family day care providers have been published by Rhode Island College and the Day Care Training Unit of Rhode Island's Department of Social and Rehabilitative Services. The materials are the result of a 3-year home day care training program, conducted by the college and the Day Care Training Unit, described earlier in CHILDREN TODAY (see "The Rhode Island Connection: A Family Day Care Training Program" by Marion J. Goldsmith, Jul.-Aug. 1979).

A Curriculum to Train Home Day Care Trainer-Consultants (84 pages) describes the work-study program developed at the college to prepare experienced family day care providers to train other providers. Designed as a 4-semester, college level course, the curriculum includes coursework in such areas as child development, family dynamics, program design and social work, together with staff development activities and fieldwork.

The materials the trainer-consultants field-tested and adapted while training other providers are presented in *Family Day Care and You* (82 pages). Included are suggestions for working with family day care providers individually and in groups and evaluating the training, and outlines for 10 training sessions on such topics as communication between parent and day care provider, child development, creative activities, discipline, health and nutrition.

Marion J. Goldsmith, former director of the Home Day Care Training Program, reports that the 10 trainer-consultants who have completed the program to date have established and staffed 10 neighborhood resource centers for family day care providers, and each trainer-consultant also works with about 30 to 40 providers in their homes—thus providing services to approximately 70 percent of the family day care providers in the state.

The curriculum materials (in loose-leaf form suitable for insertion in a 3-ring binder) may be ordered for $2.00 from Rhode Island Social and Rehabilitative Services, Staff Development Unit, Amy J. Forand Bldg., 600 New London Ave., Cranston, R.I. 02920.

Stuttering

The perplexing nature of stuttering and new techniques to help overcome the disorder that plagues about one million Americans are explained in *Stuttering: Hope Through Research*, a pamphlet published by the National Institute of Neurological and Communicative Disorders and Stroke, (NINCDS), NIH.

Stuttering, the pamphlet notes, usually begins between the ages of four and six and affects boys four times as frequently as girls. Although the symptoms are easy to identify, the cause of the disorder is still unknown. The pamphlet identifies several warning signs of stuttering in children—a rise in pitch as a child draws out a syllable, for example—and describes NINCDS-supported studies to identify the causes.

Single copies of the pamphlet may be obtained for $2.50 each from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

Reference Handbook

The 1981–82 edition of the *National Directory of Children and Youth Services* contains more than 25,000 listings of social service agencies, health departments, juvenile court and youth agencies and licensed private providers of services to children and families.

The 550-page Directory, compiled by the editors of *Child Protection Report*, also includes listings of national voluntary organizations serving young people; managers of federal agencies responsible for programs related to children, youth and families; Senate and House committees; runaway youth shelters; and federally-funded resource centers and information clearinghouses.

Single copies of the Directory may be ordered at $52.00 each (including handling) from CPR Directory Services Co., 1301 20th St., N.W., Washington, D.C. 20036.

For Physicians

The National Cancer Institute (NCI) has published an updated "Information for Physicians" booklet, based on research findings of the past five years, on exposure to diethylstilbestrol (DES) during pregnancy and before birth.

Entitled *Prenatal Diethylstilbestrol (DES) Exposure: Recommendations of the Diethylstilbestrol Adenosis (DESAD) Project for the Identification and Management of Exposed Individuals*, the booklet contains illustrations and instructions to help physicians identify DES-exposed daughters and a question and answer section to help them respond to concerns the DES-exposed are likely to raise. It also includes interviewing techniques for identifying potentially exposed mothers and children and lists of educational materials and references.

New editions of two other NCI publications for display in physicians' offices have also been published. *Questions and Answers About DES Exposure* and *Were You or Your Daughter or Son Born After 1940?*

Copies of the three publications are available free from the Office of Cancer Communications, Dept. SC, National Cancer Institute, Bethesda, Md. 20205.

Cable TV and Children

In 1981, 27.3 percent of American homes with television had cable TV, and thousands of communities are negotiating or renegotiating franchises with cable companies. How can cable TV best serve young audiences?

A number of recommendations, together with examples of what communities across the country are doing, are contained in *Cable and Children: An ACT Handbook*, a 24-page booklet prepared by Action for Children's Television (ACT).

One local effort, for example, is KIDS 4, a cable channel serving Sun Prairie, Wisconsin, that is staffed by youngsters aged eight to 13. Children create, write and direct their own programs and work as sound and camera technicians and lighting and staging designers. Founded by citizens with the support of the local cable company, KIDS 4, the booklet notes, is the first local children's channel in the country that is mandated by city ordinance.

Other examples given include children's programs produced by local cable companies and by children themselves; programs that

allow children to "talk back" to the TV and to communicate with each other via television; and a national cable channel—"Nickelodeon"—that offers 13 hours of programming, seven days a week, for children of various ages.

In its guidelines, ACT urges that cable television services for children be offered without commercials. "Because cable television is paid for by subscribers on a regular basis, it can show commercial-free programs for children," the booklet points out. ACT also recommends that cable selections include children's channels with programming for young people of different ages, and special program segments for young people on national cable networks.

Copies of the handbook are available at $2.50 each (less in quantity) from ACT Cable Handbook, 46 Austin St., Newtonville, Mass. 02160.

Understanding Criminal Law

Crime and the Law, an easy-to-read guide to understanding the criminal justice system, has been published by New Readers Press.

Written by Maxine Phillips, former director of public information for the Child Welfare League of America, the 64-page book provides an overview of basic rights, the federal and state court systems, types of crimes and trial by jury. Other sections explain rights of suspects and defendants, how to report crimes, including spouse abuse and child abuse and neglect, and how victims of crimes can obtain help. Definitions of "terms to know" are included, and case histories are used to take the reader, step-by-step, through the processes described.

Single copies of the book may be obtained at $2.95 each from New Readers Press, Box 131, Syracuse, N.Y. 13210.

BOOKS

The Challenge of Partnership: Working with Parents of Children in Foster Care

Edited by Anthony N. Maluccio and Paula A. Sinanoglu, New York, Child Welfare League of America, 1981, 225 pp., $8.95 (paper)..

Reviewed by Jake Terpstra

This collection of 13 original papers focuses on the heart of child welfare: working with the families of children in substitute care. It is one of the more encouraging books in child welfare; the central thread carried by all of the contributors is hope for broken families. It presents not simple theories or platitudes about what "someone should do" but generally down-to-earth, practical ideas with examples of successes and how they were achieved.

Two of the papers address child care in institutions, while others are general or focus specifically on children in foster family care. All deal with methods of involving parents of children in care, helping foster parents to take an active, supportive role with the child's parents, developing parent support groups, and using parents as counselors to other parents and for helping families when children return home. Some of the points around which these very informative papers are written are:

- "Foster parents can be helped to see the importance of the biological family to the child and to expand their role definition to include work with the entire family."
- Targeting three problems that led to removal of the children at a time rather than trying to tackle all of the problems at once (when there are more than three) can help the family and workers focus restoration efforts more productively.
- "These foster families seek out occasions to emphasize for biological families their importance and encourage the family's involvement. They invite them to birthday and holiday celebrations, seek their opinion on purchases of clothing and request their presence at school conferences."
- Several months after becoming actively involved a mother said, "I didn't believe you when you first told me I could be closely involved in the program, but it was more than had ever been offered to me and I gave it a try."
- "The mother described the circus outing (arranged for her and her children by the foster parents) as the turning point in her ability to hope."
- Large group projects in child care institutions, such as fall cleaning, could well include parents.
- Parent self-help groups have been beneficial as a therapeutic process for individuals in helping them relate to agencies and for causing positive system change. If such groups are to be successful, they must be autonomous from placement agencies.
- From *The Natural Parent* newsletter for parents of children in substitute care, published by the British Columbia Ministry of Human Resources: "When children have been in multiple placements someone has invested in them. Visiting old foster homes and recreating contacts with siblings can be important."
- "It often is possible to re-elicit the help of biological parents even if they have legally surrendered the child."
- "Unfortunately, we generally provide fewer services and are less committed to the success of reunions than adoptive placements. A thoughtful caseworker will realize that parents who have a child returned from foster care are likely to need more, not less, help than adoptive or foster parents, who were

chosen, at least in part, because they could perform well as parents."

Preparation of the book was supported by a grant from the Children's Bureau to the University of Connecticut, and the Children's Bureau has reprinted three chapters: *Permanency Planning in Foster Care with the Ambivalent Parent* (OHDS 81-30309) by Arlene D. Jackson and Michael J. Dunne; *Foster Families: A Resource for Helping Biological Parents* (OHDS 81-30307) by Patricia Ryan, Emily Jean McFadden and Bruce L. Warren; and *Family Involvement in Residential Treatment: A Support System for Parents* (OHDS 81-30308) by James K. Whittaker.

The book will be useful for placement agency staff, child care workers, staff of child care institutions and foster parents. While the contents are professionally challenging, many of the chapters are sufficiently forthright to be of interest to parents of children in care and to those concerned about child welfare. It is particularly relevant for agency board members and others who set policy.

A significant feature of the book is the foreword by David Fanshel of the Columbia University School of Social Work, who has devoted many of his 25 years in child welfare to research on parental involvement and who has provided abundant and solid evidence on the value of involving the families of children in foster care. "I have found it easy, in the past, to become pessimistic about the possibility of more than cosmetic changes being introduced into service delivery," he states. "But the pessimism and cynicism are beginning to give way to a sense of hope that a new way of working with parents is coming into being. This volume provides support for such a sense of optimism."

Jake Terpstra is a Social Worker Program Specialist, Children's Bureau, ACYF.

Child Abuse: An Interactional Event

Alfred Kadushin and Judith A. Martin, with the assistance of James McGloin, New York, Columbia University Press, 1981, 304 pp., $25.00.

Reviewed by Cecelia Sudia

All direct service workers and supervisors will find that this research report on child abuse has something important to say to them. A study of specific parent-child interactions leading up to and including an abuse incident, it is based on data from 830 cases reported and investigated by the Wisconsin Department of Social Services in 1974-75, and interviews with those involved in 77 cases (35.8 percent of those invited to participate). While there is undoubtedly a selection factor here—the most severe cases are missing—the sample is considered to be representative of abusive parents in Wisconsin.

The acts of over-violent discipline become more understandable as one reads about them in context: what happened at work, what the spouse said, what the child did. It is also clear that the line between acceptable and unacceptable physical discipline is very narrow and that many conscientious parents are pushed over that line during an attempt to carry out fully justified discipline. These parents need both understanding and very practical help in learning appropriate disciplinary techniques. For the most part they had valid concerns, and they usually tried other approaches before they resorted to violence.

The authors also discuss the possibilities of analyzing the behaviors which upset a parent and of desensitizing parents; of using behavior modification with certain children so that the children avoid provocative behaviors; of teaching parents and children productive fair fighting; of using the parent's concern as an entree to teaching them better methods of control; of giving recognition to the fact that physical methods do work; and of helping parents view some aspects of children's obnoxious behavior for what they are—behavior reflecting a child's age and growth level.

Cecelia Sudia is Family Services Specialist, Children's Bureau, ACYF.

Foster Care and Adoption in Canada

H. Philip Hepworth, Ottawa, Canadian Council on Social Development, 1980, 243 pp., $6.50, paper.

Reviewed by Cecelia Sudia

This report on an official Canadian study reviews the development of child welfare in each province between 1959 and 1979 within the context of broad social trends. Between the 1940s and 1960s, the population served grew two and one-half times, from 40,000 to over 100,000—and part of the problem is trying to determine why this increase occurred. "We have to recognize that simple explanations of why children come into care are inadequate," the report states. "The statistical data raise more questions than the available evidence can explain." Researchers in the U.S. will recognize this problem.

Using statistics from Ontario, which are more detailed than those from most other provinces, it appears that the total number of cases receiving services has not increased greatly, but the proportion of children placed in foster care has increased from about one-half to more than two-thirds. One puzzling factor is that the number and proportion of unmarried mothers asking for assistance declined sharply. However, the authors believe it is possible that the children of such mothers later become part of the protection caseload. But according to their statistics, the families coming into care have from two to four children while the average Canadian family has less than two.

On the other hand, protective services have changed and grown. It is possible that the changes in the statistics are a result of planned activities of protective services. Statistics from other provinces, while less complete, seem to support the interpretation that protective services have become more preventive in their operation.

To a greater degree than is true in the United States, Canadian children's services seem related to their most prominent original purpose: the placing of children of unmarried parents in adoptive homes. Both statistical reporting and legal

status in Canada reflect this approach. For instance, in Quebec the children of married parents who abandon them must stay in foster care, while a child born outside of marriage would be placed for adoption. Because of this legal orientation, and the lack of preventive services, the number of children in care in that province is large. Ontario, in contrast, has preventive services and a number of legal deterrents so that the proportion of children in care in that province is much lower.

The total number of children judged delinquent in Canada increased by a factor of four in the years between 1959 and 1973. The number of workers, supervisors, foster homes and other service agencies all increased markedly over the same period.

Slightly more than one percent of all Canadian children are in care. Twenty percent of these children are Indian or native children but even so, because of jurisdictional issues, it is believed that many Indian children are denied needed services. Most come into care because they are judged to be in need of protection—a reflection on the very poor economic and housing situations of Indian families. Once in care, the children do not move into adoption at the same rate as other children. The Commission recommends subsidized adoption and supports the Indian view that Indian children should not be separated from their cultural heritage.

A large section of the book deals with issues in adoption, the reduction in infant adoptions and the new interest in placing handicapped children. In one chapter, which analyzes the characteristics of adopting parents, the report notes a number of changes in these patterns, particularly the fact that the adoption of children by a stepparent has increased dramatically.

Overall, the report is not optimistic: "The information reviewed ... provides damning evidence of the misery hundreds of thousands of Canadian children undergo each year both in and away from their families." The failure of the federal and provincial governments is documented and the responsibility of employers, unions, churches and other social institutions identified.

Caring for Separated Children: Plans, Procedures and Priorities

Edited by R.A. Parker. London, MacMillan Press, Ltd. and Atlantic Highlands, N.J., Humanities Press, 1981, 190 pp., $31.25 cloth, $12.50 paper.

Reviewed by Cecelia Sudia

This is a report of a National Children's Bureau (London) working party to consider the care, welfare and education of children separated from their families and to examine planning in order to promote continuity and quality in their care, education and welfare.

Their survey of the types of care and reasons for it discloses a great range of alternatives—schools for delinquents, a variety of special arrangements for handicapped children and a range of foster family care, including voluntary and unlicensed care. While figures are unreliable, it is certain that a very large number of children in England are not living with their families and that this number has increased, possibly doubled, from 1956 to 1976. Although all instances of care are covered by specific law, and responsibility is fixed, the working party feels that there is definitely a question as to whether children are adequately looked after.

During the same 20-year period, there had been increasing staff turnover, changes in administrative laws, a shift to local authority, an increase in the school-leaving age (which increased the number of truants) and a divorce reform act which doubled the number of divorces—all of which contributed to a greater need for social services. Social service staff and resources were increased but these did not keep pace with need, particularly because the number of expensive residential resources were increased and efforts seemed to focus more on older children.

Suggestions for improving foster care are also discussed in the book, as is the desirability of group decisions. The key decisions—of intake, commitment, assessment and residential assessment—are discussed and the difficulties and abuses identified. The use of case review and the decision to discharge are also carefully considered. (The section on decisions might have been better had it been cast more in the "Decision Tree" format with outcomes given differential priority.)

The final section focuses on the future and discusses a range of alternatives. In general, the report is positive about residential schools but it also indicates interest in the development of community care, such as community-based, multipurpose centers.

This study is particularly interesting since it shows a system not so different from our own but one that has not experienced the "reform" movements of deinstitutionalization or the impact of adoption and foster care advocacy groups. The discussion of the intake procedures and services available when the complaint involves child abuse and neglect is not comprehensive enough, which seems to indicate that preventive work with younger children is not a priority. However, there is a discussion of prevention, and of how day care, home help, schools, health services and education for " marginal" parents might be organized to become a preventive system.

In looking at the problems of planning, the report notes that entry into care separates personal care from responsibility and that both of these may then be further divided and/or delegated. At the same time, care that is best for the child's development should be personalized, continuous and committed, although this can conflict with the child's family allegiance.

Some of these issues can be handled by involving the child in decisions about his own life, which means giving him adequate background information, and certainly parents should be involved when at all possible. Clear written agreements are recommended. The report suggests that residential staff be involved both in regard to the child and in meeting regularly with parents, and it goes on to develop a long list of questions which would need to be answered if this were done. Similarly, it discusses the role of foster parents and provides a list of specific points in regard to contracting and other concerns, many of which parallel developments in the U.S.

Beyond the Breaking Point: Problems and Service Needs of Families in Crisis

A report of the Office of the City Council President, Carol Bellamy, City Hall, New York, N.Y. 10007, October 1981, 87 pp., $3.50.

Reviewed by Cecelia Sudia

This report, issued by Carol Bellamy, President of the New York City Council, assesses the need for preventive services to New York City families at risk of having their children placed in foster care. Two-thirds of these families are headed by single parents on public assistance, with children at risk of abuse/neglect, and almost one-third live in inadequate housing. All have a great number of financial and other problems.

Many immediate problems apparently stem from the inflexibility and inadequate response of other agencies. For example, schools do not deal adequately with educational problems, and the income maintenance program, which cannot include the provision of social services, does not review the family's social situation and therefore fails to serve as an early warning system. Service programs attempting to help families find that they must develop special advocacy efforts in order to gain assistance from income maintenance, and in general, family problems are usually very advanced before the family comes to the attention of preventive workers.

The study calls for a complete reorientation of the system in order to focus on prevention.

When Pregnancy Fails: Families Coping with Miscarriage, Stillbirth, and Infant Death

Susan Borg and Judith Lasker, Boston, Beacon Press, 1981, 252 pp., $6.95 (paper).

Reviewed by Cecelia Sudia

In a letter to Ann Landers, a women requested support for her position that she should not send flowers or a card to a friend who had had a stillborn child. It seemed better not to talk about it, she said. The columnist disagreed, feeling that a friend should acknowledge this loss in an appropriate way.

Problems such as these are rarely discussed from anyone's perspective. Baby books, childbirth classes, professionals, friends and relatives all assume a normal birth and a live, healthy child. The two authors of this book also anticipated the birth of a healthy child, and the loss that they both experienced motivated them to write this excellent book.

Separate chapters discuss parents' grief and guilt, and the special problems involved in various types of loss, including miscarriage, unwanted abortion of a defective child, stillbirth and early infant death. All such parents experience shock and all too frequently a lack of support and understanding from their doctors and hospital staff. Additional brief chapters discuss the impact on the marriage, the special situation of the single mother, who may well be a teenager, the problems of siblings, the grieving grandparents and the friends and relatives who have to ask Ann Landers what to do.

Another section covers public issues, medical care, baptism, funerals and the role of the clergy and whether one should consider a malpractice suit. It also discusses new chemicals and environmental contaminents which may be responsible for some defective births. A final brief section discusses support groups and an orientation to the future. This is an excellent book in a very needed area.

Children's Humour

Edited by Paul E. McGhee and Antony J. Chapman, New York, John Wiley and Sons, 1980, 322 pp., $38.50.

Reviewed by Laura L. Dittmann

"Only humans possess a sense of humour: only humans are given to laughter" according to D.M. Brodzinsky and J. Rightmyer, two contributors to this volume. While ethologists may quarrel with the claim, this book is a scholarly treatment of an essential aspect of being human.

Both editors—Paul E. McGhee of Texas Tech University and Antony J. Chapman of the University of Wales—have contributed substantive chapters which capsulate theory and their own research. They have also collaborated on a summary of each chapter and compiled an extensive bibliography of studies on children's humor, laughter and smiling, including a subsection on infancy.

McGhee's work focuses on the child's creation of humor as differentiated from responses to cartoons, jokes and films. He also reports on a longitudinal study, with two groups of children in preschool and elementary school, which suggests that innate factors seem more highly related to humor than maternal behaviors, and that children with higher senses of humor have accelerated speech (both quality and quantity) and tend to be more responsive (or aggressive) socially with both adults and peers.

Chapman is a social psychologist who regards humor essentially as a form of communication, particularly at the group level. In his own research he uses cartoon films with groups of children to study the variables of group size, sex differences, familiarity with the material and the presence of an observer. He has found that laughter and smiling indicate different types of responses to the stimulus films. "Companionship," he explains, "tends to convert or boost humorous smiles into laughs." He reports the girls seem more likely than boys to direct their responsiveness to their companions, and that boys are more likely than girls to laugh mainly in response to the actual humor event. In either case, he is convinced that sex differences are entirely social in origin.

The other seven chapters also follow the format of an extensive review of the theoretical approach and existing research on the topic, followed by a description of the author's own research. R.B. Tower and J.L. Singer manage to bring much of the flavor and charm of the young child's imaginative play into their discussion of "Imagination, Interest, and Joy in Early Childhood." They offer persuasive rationale that fantasy and play encourage the intellect—which is particularly welcome as the "Back to Basics" peo-

ple march on. Their thesis is further developed by A.P. Davies and M.J. Apter as they consider the question, "Does humor help children learn?" In their research in the Cardiff area of Wales, they found that junior school children, aged 8 to 11, do learn and retain more when the "right" kind of humor is used. They provide a framework for determining how conditions associated with facilitatory influences differ from conditions associated with inhibitory influences, some of which are found in widely acclaimed television programs for children.

The remaining chapters deal with developmental factors: the age of onset for response to humor (which D. Pien and M.K. Rothbart set at four months) and a provocative discussion of smiling in infants as both approach and avoidance behavior; children's understanding of metaphor and the growth of ability to employ logical sequencing in storytelling; and individual differences with emphasis on cognitive style as a predictor.

This comprehensive, and expensive, text contains rich information about humor as a channel through which development in its broadest sense occurs. The editors and contributors have drawn attention to key issues, perhaps providing an impetus for further research.

Laura L. Dittmann, Ph.D., is Professor of Education, Institute for Child Study, University of Maryland, College Park.

The Young Child as a Person: Toward the Development of Healthy Conscience

Martha Snyder, Ross Snyder and Ross Snyder, Jr., New York, Human Sciences Press, 1980, 239 pp., $16.95

Reviewed by Laura L. Dittmann

The strivings, crises and growth of children attending the Chicago Theological Seminary Nursery School spring to life through the nearly 100 episodes included in this book, which is written by the nursery school director and members of her family, one of whom worked at the nursery school during a sabbatical.

Healthy conscience is conceived as developing as a child begins to care deeply for someone else. It is the authors' conviction that this occurs when the teacher takes time to understand what is going on in each situation and within each child. The teacher becomes a conduit through which children can feel cared for themselves, accept the validity of their perceptions and see how events are experienced by others.

The well-fleshed-out philosophy expressed through the episodes can be used in pre- or inservice training for teachers, parents, staff or students. An unusually provocative bibliography is provided.

Did I Have A Good Time: Teenage Drinking

Marion Howard, New York, Continuum Publishing Corp., 1980, 161 pp., $10.95.

Reviewed by Cecelia Sudia

This book should certainly be published in paperback for about $2.00 so that it would be more easily available to its intended audience. Marion Howard, now assistant professor, School of Medicine at Emory University and clinical director of the Teen Services Program at Grady Memorial Hospital in Atlanta, has long experience working with adolescents, and in presenting material in a format that is attractive and interesting to them.

The book uses three case histories—one of an adolescent boy with an alcoholic mother and a brother away in military service and two concerning girls and their various friends and families—to clearly show the impact of alcohol abuse on their relationships and on the various ways peer pressures, their parents' behavior and lack of concern and other factors interrelate to affect the outcome of these life stories.

The boy joins Alanon, and he also had the good luck to have a concerned teacher and brother. The girls were less fortunate: one was attempting to quit drinking after her best friend lost an eye in a motor accident in which a drunken boyfriend was driving; the other is arrested while breaking into an apartment to steal some whiskey. The case stories are interspersed with brief explanatory notes, but the stories really carry the content of the message.

TV On/Off: Better Family Use of Television

Ellen B. DeFranco, Santa Monica, Goodyear Publishing Co., 161 pp., 1980, $7.95 (paper).

This excellent, well-written book for parents of school-age children offers a variety of techniques and approaches to meeting the problem of controlling the family's viewing habits. Some of the recommended activities sound so interesting that the book's major usefulness may lie in its suggestions for family activities in general.

The book is not anti-TV. Many of the suggestions deal with choosing intelligent programming, critical analysis of programs watched and other opportunities for parent-child interaction around this important activity.

Cecelia Sudia

Teenage Parents and Their Offspring

Edited by Keith G. Scott, Tiffany Field and Evan Robertson, New York, Grune & Stratton, Inc., 1980, 328 pp., $24.50.

This excellent compilation discusses three major consequences of teenage pregnancy. Part one covers epidemiology, with additional chapters on cost to the government, legal issues, psychological factors and nutrition. A second section assesses outcomes for the children while the final section reviews the advantages to be gained from interventions.

Probably the most innovative research is a socioeconomic analysis which, using a variety of national population statistics, concludes that out-of-wedlock births are positively related to black ethnicity, higher incomes and increased age at first marriage. They are reduced by the availability of abortion, the presence of family planning clinics and higher involvement in the labor market.

The editors are to be commended for providing so much information in concise form.

Cecelia Sudia

Family Relations, Vol. 30, No. 4, National Council on Family Relations, 1219 University Avenue, S.E., Minneapolis, Minnesota 55414, 1981, $5.50.

This special issue on Family Life Education contains 21 articles on a wide range of issues and resources relating to the subject. Included are analyses of values, objectives and goals; descriptions of programs and of the special advantages and perspectives of religious and community settings; and discussion of audio-visual materials.

In addition, there are articles assessing the relationship of family life education to research and evaluation and its use as a mode of intervention. Also included is an excellent article on the needs of women in the criminal justice system. Missing, however, is an analysis of programs for families at risk of losing children into foster care because of inadequate parenting. Overall, practitioners in the field will find the book an excellent resource.

Cecelia Sudia

Revisions to Note

Parents and Children Learn Together, Third Edition

Katherine Whiteside Taylor, 1981, New York, Teachers College Press, Teachers College, Columbia University, 1981, 386 pp., $26.95, cloth, $16.95, paper.

Reviewed by Judith Reed

Katherine Whiteside Taylor has been involved in education for more than 50 years, and in the parent-cooperative preschool movement since its inception. This "enriched" edition of a work first published in 1968 is divided into two parts. The first section discusses family life and childrearing under the general heading of "Guiding Children's Growth," with separate chapters focusing on such aspects as discipline and helping children channel emotions. The second half of this unusual, warmly—and wisely—written book is devoted to "Developing and Extending Parent Cooperative Nursery Schools."

The first such school in the United States, Dr. Taylor tells us, was organized in 1916 by 12 faculty wives at the University of Chicago who wanted to have some free time to do volunteer Red Cross work during World War I. Other parent cooperative nursery schools followed in the 1920s and Dr. Taylor served as the first director of what is now the oldest existing cooperative nursery school "started and carried through by parents under a trained teacher": the Children's Community, which opened in Berkeley in 1927.

In nine chapters, Dr. Taylor discusses the history, value and functions of such schools and offers a detailed guide on how to start and operate one. The scope of this section is broad—it ranges from the details of budgeting to interesting discussion of the quality of parent involvement and learning that takes place in these schools and the interactions between and among parents, teachers and the community. Sources of information and materials on parent cooperatives and child development are included in an appendix.

The Child's Generation: Child Care Policy in Britain, Second Edition

Jean Packman, London, Basil Blackwell and Martin Robertson, distributed by Biblio Distribution Centre, 81 Adams Drive, Totowa, N.J. 07512, 1981, 202 pp., $12.50

This book is a detailed analysis of child welfare policy in England from 1948 through 1971. It discusses the background of problems which led to the passage of particular acts and analyses the consequences of these legislative and systems changes. Most of the illustrative case material and statistics relate to the two counties of Oxfordshire and Devon.

The English system has experienced all of the same difficulties and problems recognized in the United States. The book, first published in 1975 and now revised and updated to cover recent changes in law, should be of great interest to all students of child welfare policy.

C. S.

Don't Push Your Preschooler

Louise Bates Ames and Joan Ames Chase, Revised Edition, New York, Harper & Row, 1981, 214 pp., $11.95.

This new edition of a work which first appeared in 1973 includes, in addition to overall revision and updating, a new chapter on food and health. Dr. Ames is associate director of the Gesell Institute of Human Development and a co-founder (in 1950) of the Gesell Institute of Child Development. Her co-author and daughter, who died in 1974, was a child psychologist.

Addressed to parents, the material covered ranges from such advice as is contained in chapters headed "Don't Push Because . . ." and "What you *Can* Do" ("Know What to Expect," "Help Your Child to Know Himself," "Read to Them") to "Common Problems and What to Do About Them" and "School and Your Preschooler." A useful list of 77 recommended books for parents is included.

J. R.

letters

The Holocaust

The September-October 1981 issue of CHILDREN TODAY is, I believe, one of the most important events in the lives of American Holocaust survivors and their children since both groups were forced forever to be categorized in such terms by the events in Europe between 1939-1945.

For the first time, Yael Danieli, in her article "Differing Adaptational Styles in Families of Survivors of the Nazi Holocaust," has allowed survivors and children of survivors to understand the nature and consequences of their familial interrelationships in clear, pronounced and brilliantly conceptualized terms. I cannot overemphasize the importance for survivors and their children of finally having points of reference from which to try and understand their particular pasts.

I belong to one of the first groups of children of Holocaust survivors founded in the United States. For over four years, nearly two dozen of us have been comparing notes on our lives as children of survivors. We have learned much about each other, above all, perhaps, that we were not, as many of us once thought, the only ones in the entire world growing up as we did. Yet Yael Danieli, in the space of a few pages, has crystallized the common experiences of our parents and ourselves as we could not have imagined possible. The "conspiracy of silence which shrouds (our) lives," as Danieli has termed it, will never the the same again.

Abraham J. Peck
Associate Director
American Jewish Archives
Cincinnati, Ohio

R.S.V.P.

The Retired Senior Volunteer Program (RSVP) of Dane County, Wisconsin is developing a National Clearinghouse for Intergenerational Programs and Issues.

We would like permission to reproduce the article, "Young and Old Together" by Carol Seefeldt (CHILDREN TODAY, Jan. 1977) for distribution in response to requests on intergenerational programming.

Mary Stamstad
Executive Director
Retired Senior Volunteer Program
Madison, Wis.

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Editor

Mothers Without Custody *(Continued from page 15)*

custody although it is "mainly important to me to find responsive people to talk with. However, I rarely talk about the fact that I do not wish to have custody of my children right now."

"Women who do not have custody deserve more understanding and support from friends and relatives," Ms. Brown asserts. "They have made a very painful and difficult decision which has often been thought through very carefully."

The women whom I interviewed feel a sense of loss concerning their children, although they have not abdicated the role of nurturing parent. As one mother said, "I have memories of my eldest at age nine coming home from school. I realize I'll never have the same memories of my youngest."

All three mothers see their children regularly. Their predominant feeling is that leaving their children in the custody of the father was the best possible decision at the time. In each case, the women needed not only to recover a sense of themselves but also to establish for themselves an image of wholeness and worthiness. The extent to which these women are able to establish a positive self-image depends on several factors, including the finding and building of a satisfying and economically rewarding career while building a network of supportive friends—no small task for anyone.

Deciding to be a non-custodial parent, whether male or female, is not easy, to say the least. However, mothers who voluntarily relinquish custody face many more difficulties than fathers in regard to society's acceptance of them. Perhaps, "as society comes to accept non-custodial mothers as it has non-custodial fathers," says a counselor with Tobler and Milne, "there may also be more acceptance for parents who give up custody for other reasons, such as handicaps of the children or themselves, or in times of high family stress." ■

[1] *Facts on Women Workers*, Women's Bureau, U.S. Department of Labor, 1980.
[2] Bureau of the Census, *Current Population Reports*, Series P-23, No. 112, Sept. 1981.
[3] *Women in Management*, Women's Bureau, U.S. Department of Labor, 1980.

Neglecting Families *(Continued from page 9)*

Families are the nurturing centers for the development of our children today. It is important that these children receive the necessary support, acceptance and opportunities for personal growth in their interaction with their world. When this is thwarted, it is imperative to intervene early and quickly in order to interrupt chronic generational neglect, and to help parents and children work together in meeting the growing demands of today's world. ■

[1] American Humane Association, *National Analysis of Official Child Neglect and Abuse Reporting*, Denver, Colo., Denver Research Institute, 1978.

[2] Copies of the Child Neglect Severity Scale may be obtained from Marilyn Hall, Children and Youth Project, 800 Stemmons Tower North, 2710 Stemmons Freeway, Dallas, Tex. 75207.

Foster Parents *(Continued from page 5)*

entirely different set of learning needs.

Foster care education could be divided into levels. For example, one level would provide every member of the team involved in foster care (both workers and foster parents) with training in the same conceptual framework.

Another level would offer foundations for practice and training for prospective foster parents and new caseworkers in foster care dynamics. Yet another level involves advanced practice for foster parents and workers, teaching child management and communication skills and components on such specialized care as working with children with handicapping conditions.

- *The team approach.* Foster parents who perceive themselves as part of the casework team tend to be more assertive about their role in the system and they tend to take more responsibility for self-development and meeting agency goals. As a first step, an agency might want to assess values, attitudes and practices among current workers, foster parents, supervisors and administrators to see where inconsistencies may exist.
- *"Paychecks" or reinforcers.* Perhaps the time will come when foster parents are salaried, as are day care providers and child care workers. Until then, other kinds of reinforcers must be identified. What makes a foster parent's job rewarding is usually similar to what satisfied workers find rewarding.

Both say that what they like about their job is the challenge and the opportunity to meet many new people; it is a learning experience and it allows some flexibility in working outside an office. Other positive features include the opportunity of working with many different people and teaching others to help themselves.

On the other hand, a salary plus job benefits, such as insurance or the possibility for promotion, are factors for workers.

Foster care payments are usually inadequate, often not even covering the costs of caring for the child. And not only do foster parents receive minimal financial compensation for their work, but they generally have to spend their own money to do the job. In addition, there is often no insurance or other fringe benefits for them, and, unfortunately, no room for promotion.

In recruiting and retaining foster parents, an agency must list all of the reinforcers and then make sure they are as regular as a payroll check: the right to receive a realistic challenge; opportunities for growth and skill development; ongoing recognition for quality service; professional and moral support; and opportunities for success and job satisfaction.

Conclusion

In summary, many external factors work to decrease the potential foster family population in our country. Methods of recruiting and retaining foster families to compensate for those factors, however, are within the reach of agencies committed to planning and consistency. But agencies must truly believe that foster parents who are recruited and trained in a teamwork role can provide some of the extra energy needed for the delivery of foster care services in the years ahead. ■

[1] L. John Bohman, "Methods of Recruiting Foster Homes and Ways to Enable Foster Parents to Help The Children," *Child Welfare*, Dec. 1957.

[2] For additional examples of recruitment techniques and specific suggestions for working with the media, see *Foster Parenting*, Office of Juvenile Justice and Delinquency Prevention, Law Enforcement Assistance Administration, U.S. Department of Justice, Dec. 1978; *Foster Care Recruitment and Training Packet*, Foster Parent Association of Utah and the Division of Family Services, Region III Office, State of Utah, 1973; *Developing a Foundation for Foster Family Recruitment and Retention: A Training Manual* by Eileen Mayers Pasztor and Elyse M. Burgess, Foster Parent Project, Nova University, Ft. Lauderdale, Florida (in press); and *How to Plan and Conduct an Effective Adoption Recruitment Campaign*, DDHS Publication No. (OHDS) 81-30311, Washington, D.C., May 1981.

[3] For a study of foster parent demographics, referral sources, recruitment and licensing outcomes, see "The Difficult Job of Recruiting Foster Parents" by Robert M. Friedman et al., *Public Welfare*, Summer 1980.

[4] For a study of how an agency used the mutual selection process and preservice training to increase foster parent licensing rates, performance and workloads, see "The Effect of Nova Foster Parent Selection and Training on Agency System Operations" by Donald D. Simon and Denise K. Simon, *Child Welfare* (in press).

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OFF TO A GOOD START: A Resource for Parents, Professionals, & Volunteers. DHHS, OHDS, ACYF, Office for Families. Publication No. (OHDS) 81-30304. 1981. 279 pp. Single copies free from LSDS, Dept. 76-C1, Washington, D.C. 20402.

Addressed to parents and professionals working with families, this publication contains more than 250 abstracts describing programs, publications, films, training courses and other materials of special interest.

PROMISING PRACTICES: Reaching Out to Families. DHHS, OHDS, ACYF, Office for Families. Publication No. (OHDS) 81-30324. 1981. 61 pp. Single copies free from LSDS, Dept. 76-F1, Washington, D.C. 20402.

Directed to community leaders, parent educators and other professionals working with families, this publication describes 53 family-oriented programs that can be adapted for use in communities across the country.

DENTAL CARIES PREVENTION IN PUBLIC HEALTH PROGRAMS. DHHS, NIH, PHS, National Institute of Dental Research. Publication No. (NIH) 81-2235. 161 pp. Single copies free from the National Caries Program, NIDR, Westwood Bldg., Room 549, 5333 Westbard Ave., Bethesda, Md. 20205.

The proceedings of a symposium, held in October 1980, which discussed the safety of water fluoridation, alternative methods of delivering fluorides, aids for implementing self-applied fluoride programs and the role of sugars in dental caries.

THE COURSE OF LIFE: PSYCHOANALYTIC CONTRIBUTIONS TOWARD UNDERSTANDING PERSONALITY DEVELOPMENT. Stanley I. Greenspan and George H. Pollock, Editors. DHHS, PHS, ADM, National Institute of Mental Health. Vol. 1, "Infancy and Early Childhood" (SN 017-024-01026-0), 660 pp., $13.00; Vol. 2, "Latency, Adolescence and Youth" (SN 017-024-01027-8), 550 pp., $12.00; Vol. 3, "Adulthood and the Aging Process" (SN 017-024-01062-6), 608 pp., $12.00.

These three volumes, which include original contributions by Anna Freud, Erik Erikson, T. Berry Brazelton and other scientists and clinicians, present a framework for studying and understanding human personality development across the lifespan and in the context of biological, psychological and social environments.

CARING FOR KIDS, two new pamphlets in the series produced by the Division of Scientific and Public Information, National Institute of Mental Health. Single copies free from Public Inquiries, National Institute of Mental Health, 5600 Fishers Lane, Rockville, Md. 20857.

- "Learning While Growing: Cognitive Development" (Publication No. (ADM) 81-1017. 1981. 14 pp. Discusses how children acquire language skills and develop understanding and memory, levels of thinking, altruism and conscience.
- The Importance of Play. (Publication No. (ADM) 81-969. 1981. 16 pp.) Describes how children learn and develop through play.

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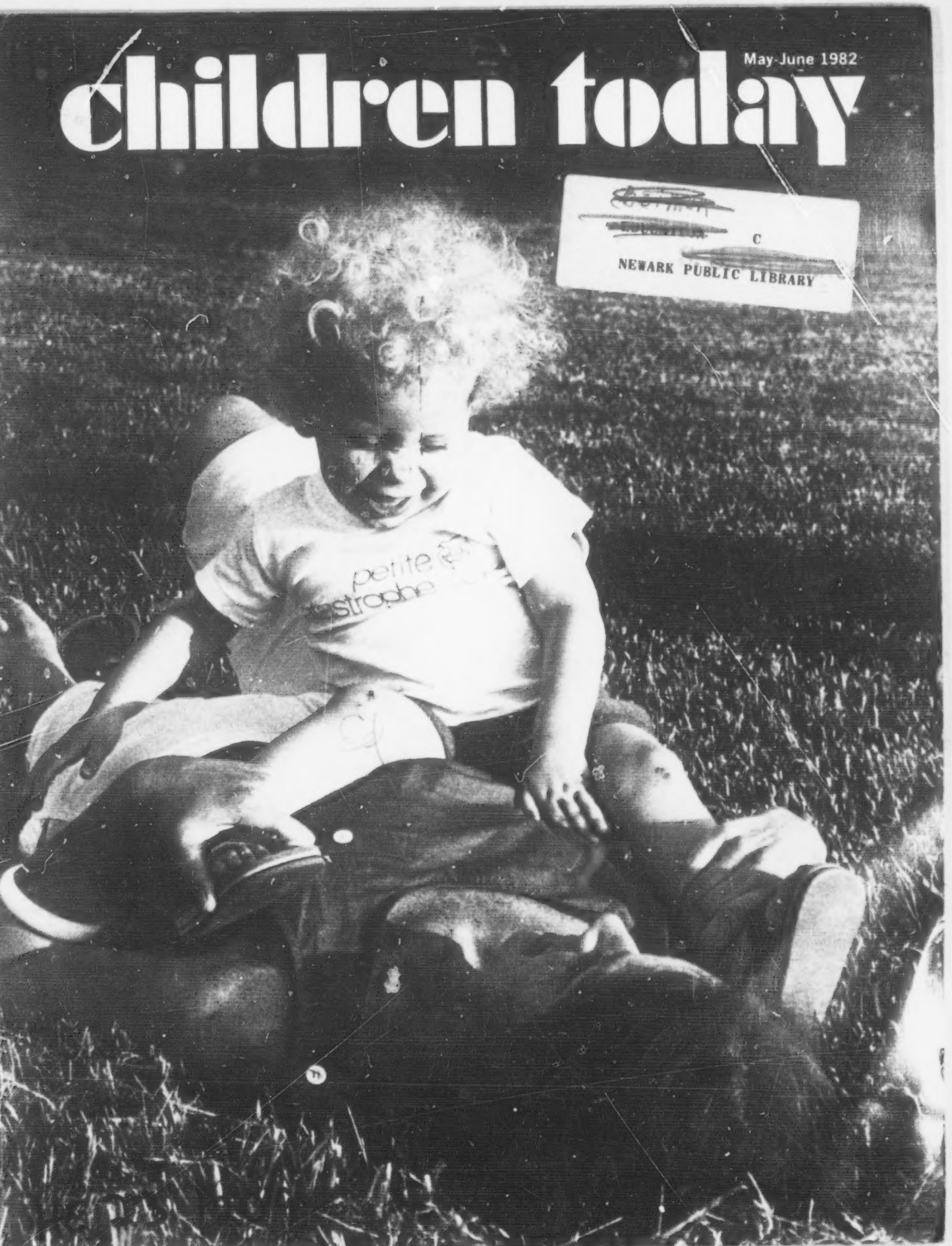
May-June 1982



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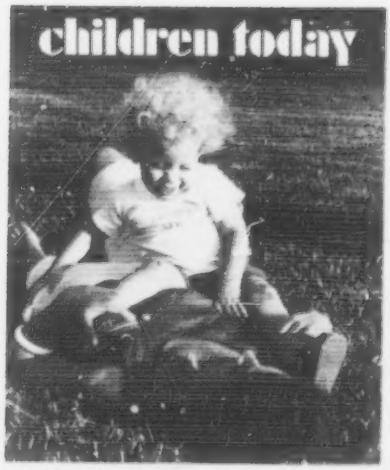

☐ Where is the line to be drawn between an educational service and medical treatment? What health-related services can and should we expect a schoolteacher to perform? These are some of the issues discussed in our first article, "Doctor, Do You Make (School) House Calls?"

Two factors have contributed to the present concern with school health problems and how to deal with them. First, Public Law 94-142, the Education for All Handicapped Children Act of 1975, mandates free appropriate public education for all handicapped children, a term that includes those with such recognized impairments as mental retardation and "other health impaired" children—among them those with "limited strength, vitality, or alertness, due to chronic or health problems such as a heart condition, tuberculosis, rheumatic fever, nephritis, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, leukemia or diabetes. . ."

And not only are more such children in public school as a result of the Act but medical advances in recent years have controlled many children's illnesses enough so that more of them are no longer confined to their homes or a hospital and can now attend school.

Author Richard E. Ekstrand, a Maryland lawyer with a special interest and knowledge in the subject, reviews questions and issues involved in the schools' increased responsibilities regarding student health care, how some courts have ruled when problems could not be resolved otherwise, and some of the procedures that have been cooperatively worked out by physicians, lawyers and school personnel.

☐ Child care for children of working parents—that ever-timely and important subject—is the focus of two articles this issue. One describes Seattle's approach to training day care providers while the other offers a practical guide to setting up day care centers at conference sites.

In the Seattle, Washington metropolitan area, where 14,000 children under age six have working mothers, the Seattle Day Nursery operates three vans that bring information and resources to day care homes and centers in the city and surrounding suburban and rural areas. Since the program began, with one van in the inner city in 1976, 350 homes and centers have received training and materials, and about 85 additional day care homes and nine centers are visited each year. Pamela Mauk, formerly of the staff of the nursery, and Patrick L. Gogerty, director of Seattle Day Nursery, describe the program, beginning on page 7.

Julie Carvalho, mother of five and an evaluation specialist in the Office for Civil Rights, DHHS, serves as the child care specialist for Federally Employed Women (F.E.W.) and chaired the child care committee for the 1980 F.E.W. National Training Program. Her experience in setting up a center for that conference forms part of her article, "Child Care at Conferences: A Family Approach" (see page 11).

☐ The period of pregnancy is no longer viewed as a static, passive waiting period, Deborah Valentine writes in "Adaptation to Pregnancy: Some Implications for Individual and Family Mental Health." Rather, she says, pregnancy is becoming acknowledged as a critical point in the psychological life of the expectant parent and the family system, and how individuals cope, adapt and confront issues raised during the pregnancy will influence both the family as a unit and its members. Her article, which begins on page 17, reviews what research tells us about aspects of pregnancy and later family adjustment, and how this knowledge can be used to provide treatment, emotional support, education and preventive services to expectant parents.

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Doctor, Do You Make (School) House Calls?

by Richard E. Ekstrand

It is spring, the weather is perfect, with a slight breeze drifting through the open window. The child is quietly reading a book. Suddenly, a small intake of breath and a scream. Redness, swelling, hives appear on the child's face and body. The child's medical records indicate a critical sensitivity to certain substances and the instructions on handling such an emergency say that medication by hypodermic injection should be given within minutes—this is a life-threatening situation.

Check the prescription. Locate the medication. Ring the emergency button and get some assistance. The minutes are ticking away.

Not an unusual drama: life-threatening situations occur in hospitals every day. But this is not a hospital—it is a third grade classroom and the child is critically sensitive to bee sting venom. The classroom teacher has no medical background. The help on the other end of the emergency button may be a school aide, another teacher or, at best, a school health nurse. The physician who prescribed the emergency procedures and medication is not within easy reach.

The situation described above illustrates the changing scope of medical and educational services today when a child's parent, physician and teacher must work cooperatively to resolve school health problems.

Richard E. Ekstrand, an attorney in the private practice of law in Maryland, represents school systems on a regular basis. His article is based on a presentation made at a meeting of the American Academy of Pediatrics in New Orleans last November.

The seriousness of school health problems and the need to deal with them have been magnified by Public Law 94-142, the Education for All Handicapped Children Act, which mandates free appropriate public education for all handicapped children. As defined, the term "handicapped children" includes those with such recognized impairments as mental retardation and those classified as "other health impaired" children. The latter term implies a very broad scope, as borne out in the federal definition: "Other health impaired means limited strength, vitality, or alertness, due to chronic or health problems such as a heart condition, tuberculosis, rheumatic fever, nephritis, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, leukemia, or diabetes, which adversely affects a child's educational performance."

In the not too distant past, such health impairments often precluded school attendance. Medical advances have not eliminated these illnesses but they have controlled them enough so that a child who might formerly have been confined to hospital or home can now attend school.

By way of example, let me share two diagnostic profiles of children presently attending public schools:

John: Left hemiplegia, generalized hypotonia, psychomotor delay, hyaline membrane disease, seizure disorder, intraventricular hemorrhage and hearing loss.

Alice: Prematurity, heart murmur, cerebral palsy, scoliosis, retrolentil fibroplosia, glaucoma, cataracts, hearing loss, mental retardation, rickets, chronic malnutrition, allergies to all milk products and oatmeal, Vitamin B12 deficiency and other problems.

With the inclusion of such children in public school programs, the monitoring of illnesses and the provision of medical-type services must also take place there. Who then has responsibility for the care of these children in school? Some say we all do—parent, physician, schoolteacher and even lawyer. Let's see, however, what Public Law 94-142 says about that.

The definition of handicapped children in Public Law 94-142 refers to children who, because of certain impairments, require special education and related services. Under the law, the term "related services" means, among other things, "such developmental, corrective, and other supportive services as are required to assist a handicapped child to benefit from special education and includes medical services for diagnostic and evaluation purposes." Thereafter, "medical services" are defined as "services provided by a licensed physician to determine a child's medically related handicapping condition which results in the child's need for special education and related services."

Have we now answered the question of who has what responsibility for the medical condition or needs of the child during school hours? Not yet, it seems. You see, PL 94-142 addresses medical services for diagnostic and evaluation purposes only. It does not mention "treatment." It would appear to follow that a school system is therefore relieved of responsibility when the child needs treatment that must be administered by a licensed physician. We have now reached the crux of a major problem. What treatments must be administered by a licensed physician? In other words, what medical and health-related services can be rendered competently by a schoolteacher? Where is the line to be drawn between an educational service and medical treatment?

In our litigious society, we have all too frequently and quickly turned to the courts for answers to our problems. Following this tradition, some of the new school health problems have already been submitted to judicial review. Courts have been asked to decide the degree to which students identified as hepatitis B carriers can be integrated into the general school population, when at the same time all members of the medical community do not completely agree on the health risks involved. Similarly, courts have had to wrestle with the question of whether a schoolteacher is competent to treat and therefore must provide clean intermittent catheterization for a spina bifida child. A close examination of the latter case, *Tatro v. State of Texas*, reveals the many questions surrounding this issue.

The student involved in the case was a 5-year-old girl with spina bifida. As a result of this birth defect, she suffers from orthopedic and speech impediments and a neurogenic bladder. Because of her bladder condition, she is unable to void voluntarily and must be catheterized several times each day. The method of choice is Clean Intermittent Catheterization (CIC). Simply put, the issue in this case involved whether or not CIC is a "medical" service, and thus not covered by the Education for All Handicapped Children Act, or is a "related" service and therefore must be provided by the school system.

In discussing the procedure the Court provided this historic perspective:

"Despite its present widespread use, CIC has become an accepted procedure only in recent years. Before CIC became an accepted practice, a substantial number of physicians believed that penetration of the urethra ought to be done only in a sterile environment with sterile instruments. The only alternative entailed exerting manual pressure technique. however, [it] presented a risk of reflux of fluid and injury to the kidneys. CIC is a far more simple procedure. The catheter need not be sterile nor must its use be confined to a sterile environment. Obviously, CIC requires relatively less direct medical superintendence than this earlier used method."

Emergency treatment is the major concern of physicians and school personnel.

In this case the Court decided that CIC is a related service and required the school system to provide it. The rationale for and discussion of this decision is of vital interest in considering our original question: where should the line between an educational service and medical treatment be drawn.

The U.S. District Court, Northern District of Texas, Dallas Division, stated:

"This Court is here construing an Act of Congress of nationwide application. And it ought to be given a uniform construction. Yet Congress, by defining the Act's reach by definitions locatable only in the law of the respective States, perforce intended, at least to this extent, that its construction be parochial. A contrary view would require a finding that Congress intended to alter patient-doctor relations in the several States. Stating the proposition answers it. *The types of medical treatment that can be performed by nonphysicians, and the extent to which any treatment must be under the control and supervision of a licensed physician, are regulated by State law. And the Courts must look to State law to determine whether a service is a medical service.*" [Emphasis supplied.]

The Court continued:

"This Court has been forced to inquire into the legal responsibility of Texas physicians to control and supervise prescribed treatment, a subject that has received little judicial attention. The task includes fitting together a three-party relationship: the school district, the child and the child's doctor. . . . *At a practical level it makes little sense to require school districts to provide a service that cannot be provided without a prescription if physicians will not write them for fear of running afoul of their own Practice Act and the demands of their malpractice insurance carriers. . . . A physician, however, may prescribe treatment to be performed by another individual or an institution if he believes that individual or institution capable of providing the prescribed service in a competent manner. . . . Nor is the physician obligated to supervise directly the treatment he has prescribed; his duty is to ascertain that the person or institution providing the treatment in conformity with his prescription is adequately qualified.*" [Emphasis supplied.]

The Court also said:

"A physician thus may prescribe CIC to be furnished by a school district if he believes that the district has personnel qualified to perform

CIC . . . In sum, the Court is persuaded that furnishing CIC does not constitute the unlawful practice of medicine when performed by professional nurses in accordance with valid medical prescription."

In a footnote to the discussion of nurses providing CIC, the Court extends its opinion by pointing out that it does not hold that CIC can only be performed lawfully by professional nurses and that "lay persons, with proper medical training, may, in accordance with a valid prescription, provide treatment that without such training and prescription would be considered unlawful practice of medicine."

Have we now raised another question which must be answered? What constitutes "proper medical training"? And, again, who shall have the responsibility for that training?

Another footnote in the Court opinion is of interest:

"It is unclear whether a physician is liable for independent acts of negligence of school district employees performing services in conformity with his prescription. In *Sparger v. Worley Hospital, Inc.*, 547 S.W.2d 582 (TX 1977), the Texas Supreme Court rejected the 'captain of the ship' doctrine in favor of the borrowed servant doctrine. Arguably under *Sparger*, the prescribing physician would not be liable for independent acts of negligence by school district employees as long as he exercised ordinary care in prescribing that the treatment be performed by school district personnel. But, to the extent that a physician controls, supervises, or instructs unlicensed persons providing nursing care, he may be liable for their acts. . . .It does not appear that a prescribing physician exercising ordinary care would be liable for the school district's negligence simply because he prescribed the treatment. But the question has not been dispositively resolved by the Texas Courts."

As this review makes all too clear, the significance of these lawsuits is not found in the rulings rendered by the Courts, for they have fallen far short of resolving the problems. The significance is that our most highly educated professionals—schoolteachers, doctors, lawyers—have been unable to resolve school health issues by cooperatively working together and have thus resorted to the Courts.

Some professionals in education, medicine and the law, however, have worked together on occasion. One area which has received considerable attention in recent years is that of health care for allergic children. In many places throughout the country physicians, lawyers and school personnel have met to work out elaborate procedures which encompass identification of allergic pupils, limitation on use of materials of an allergic nature, environmental controls and emergency procedures.

Although a great deal of attention has been given to the emergency procedures, the major purpose of these school policies is to provide protection to pupils against unnecessary exposure to allergens and to other conditions that may affect their health or well-being. In short, a major focus of efforts has been prevention.

Where should the line between an educational service and medical treatment be drawn?

Most of these procedures share several features designed to inform school staffs about allergen control in schools. Components of such programs include:

- *Knowledge of Allergens:* Preparation of lists of common allergens which should be recognizable to all personnel.
- *Identification of Allergic Pupils:* The maintenance of lists of allergic pupils for the purpose of screening against school events and schedules that might cause allergic reaction.
- *Recognition of Allergic Reaction in Pupils:* The conduct of inservice meetings to assist teachers in the early recognition of pupils undergoing allergic reaction.
- *Limitation of Materials of Allergic Nature:* The maintenance of appropriate purchasing procedures for all school and classroom materials.
- *Environmental Controls:* The maintenance of procedures regarding temperature and humidity control, air purification, cleaning routines and insecticide/pesticide spraying.

Of course, emergency treatment is the major concern of physicians and school personnel. Getting medication to the student, either to prevent an emergency or to respond to an emergency, is of vital importance. Some states have passed legislation dealing with the administration of medical preparations by school personnel. These regulations specifically indicate that non-medical personnel, such as principals or teachers, may administer medication orally or by injection by order of the physician and authorization of the parent or guardian. The intent of this type of legislation is to eliminate unnecessary trips from the school to a doctor's office, hospital or the child's home and to extend the caretaking responsibility of the school in the absence of the parent. Where such legislation exists, it has attempted to safeguard these procedures by requiring certain standards to be met. Some examples of standards include the following:

- Physicians' orders for medicinal preparations to be administered shall specify, in writing, the duration of the order and the name and dosage of the drug. The orders should be renewed each school year.
- Each school shall keep a bound book with consecutively numbered pages in which the administration of medicinal preparations are recorded in ink, showing in each case the date and time of administration, the name of the student, the kind and quantity of medicinal preparation, the name of the prescribing physician and the signature of the school nurse, principal or teacher administering the preparation.
- The specific written order of the physician and the written authorization of a parent or guardian shall be kept on file and all authorizations shall be renewed each school year.
- Not more than one month's supply of a prescribed medication shall be stored in a school. The medication

(Continued on inside back cover)

A Tale of Two Families

by Helen Hessler

Richard in 1980, before his kidney transplant.

Richard, at 14, has two families; his foster family and his biological family. They both came through for him in great style.

Richard has just undergone a kidney transplant. The near-miracle involved in this is a story Richard would like everyone to know.

Born to a teenage mother who elected to release her baby for adoption, Richard began life with serious kidney damage that had developed *in utero*. One kidney was removed when he was just a few weeks old. The second one had only about 50 percent of its function and that was reduced drastically as he grew older.

As an infant Richard was placed by Lutheran Social Services in a temporary foster home. The plan for him was adoptive placement as soon as possible after surgery and the stabilizing of his kidney function. However, in the 1960s adoptive families were often reluctant to consider a baby with any high risk medical condition. Richard presented unusually high risks and no adoptive family was found for him.

Richard's foster parents realized the situation and never waivered in their total commitment to him. After he had been in their home for two years, it was agreed that the love and security he had found there should not be interrupted. Adoption was not a step they could take easily, however, in view of the costs of Richard's medical care and frequent hospitalizations. Since there was no adoption subsidy legislation to help, Lutheran Social Services worked out a transfer of custody to the Department of Welfare so that support for his care would be readily available.

The next several years were ones of pain, hope and frustration as far as Richard's health was concerned. Many medical and surgical procedures were needed to maintain his kidney and bladder functions and he was often hospitalized for weeks at a time. In 1968, he had to stay in Children's Hospital, Washington, D.C., for three months.

Richard suffered emotionally because of the unending medical procedures. He developed a fear of clocks, which seemed to be related to the many dials on the equipment he stared at during lonely hours in the hospital. He was never free of many restrictions. For example, he couldn't drink ordinary water but had to keep his kidney flushed with quarts and quarts of potassium-free water. This often meant taking along water wherever he went. Finally, his urinary tract became so damaged from infection that a cystostomy became necessary. Richard then had to empty the urine bag several times each hour.

The interruptions to his schoolwork and his difficulty in competitive sports depressed him. He did develop a love of swimming and his foster parents made every effort to take him once a year to Florida for the fun of swimming in the ocean in the winter months.

Throughout these years, as kidney function decreased, Richard and his foster family were very aware of the high risk to his future. Medical science could only postpone the inevitable. The demands of his growing body on the remnant of his one kidney would one day be overwhelming.

As he grew older, Richard also was disturbed by his status as a foster child. His family was very loving and supportive, but his name was different from theirs.

All their reassurances that he would never have to leave them did not make up for that. He had many fantasies about his birth parents but only a few facts. He also had a lot of anger, often associating his mother's relinquishment of him with his kidney problem.

When he was in his early teens, Richard knew that one day he would need a kidney transplant. The doctors were honest with him. The kidney of a non-relative donor might easily be rejected by his body. The greatest chance of success would be with the kidney of a close relative—a parent or sibling.

A fantasy hope began to develop that his birth mother would come and save his life. His foster parents worried now more than ever. They realized the complications of this set of circumstances. There were many conversations among the social workers, foster parents and doctors. A psychiatrist seeing Richard

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Helen Hessler, ACSW, is director, Adoption Services, Lutheran Social Services, Washington, D.C.

regularly to help with his emotional conflicts had advised against any contact with his birth family during early adolescence. Richard was ambivalent. His desire to know his birth family and his hope for restored health were offset by a fear of losing his foster parents.*

Nature forced a break-through in this impasse when Richard was 14. His kidney function had dropped to 20 percent and his trips to the hospital were more frequent. His doctors made a formal request for help in locating his biological family, to determine whether a compatible kidney donor could be found. The public agency passed the request along to Lutheran Social Services and a search was begun.

Richard's grandparents were located first. They lived within 100 miles of Washington, D.C. The first telephone call they received, describing the need of a 14-year-old grandson they had never seen, was a shock and they needed time to absorb it. They also reacted with protective feelings for their daughter, who now had a good marriage and a settled life.

Luckily, there was time to work through these feelings and they were able to tell her. Within a few weeks, both the mother and the grandmother met the social worker for a long discussion. Although Richard's mother was concerned, she was also reluctant to become involved, fearing the effect of the new situation upon her marriage.

Other family members were asked to consider the possibility of becoming donors. Pictures of Richard were shared, along with information about his personality, school and health. No face-to-face meetings were planned then. Richard counted so heavily on the hope of a kidney that everyone was hesitant to move too fast.

In the spring of 1981, as Richard faced the removal of his kidney remnant, he requested that his name be legally changed to that of his foster parents. The security this would provide was clear to everyone. His social worker and legal counsel moved quickly to determine that the biological family had no objections. The legal name change that followed was like a gift to Richard. He no longer worried about meeting relatives. His sense of belonging seemed complete.

With the kidney out, dialysis followed on a daily basis. Because of his medical history and the continued deterioration of his physical condition, he was a poor candidate in many ways. In spite of this he was cheerful and optimistic about the future. Richard often shared with those he trusted his hope of one day becoming a doctor, especially a pediatrician. He thought he would understand the feelings and struggles of children who had, like himself, suffered years of illness.

During these weeks, with no prodding from anyone, his biological family had quietly come to a decision. Two members, his grandmother and uncle, arranged with his doctors for preliminary tests for donor compatibility. Richard's grandmother checked out well. She was overage, however, and for a time there was uncertainty that she could become a donor. Further tests were ordered and a week-long hospitalization was arranged.

When all the kidney function tests proved that she would be a good donor, his grandmother's desire for a meeting grew. Richard's foster mother thought he was ready. The hospital psychologist checked it out with Richard and had no reservations. With no fanfare, the two finally met. Richard was happy to meet his grandmother and was pleasantly surprised to learn that all his relatives were cheering him on to recovery. He knew that he would eventually meet them all.

After months of building up Richard's health and stamina, the kidney transplant was scheduled. His grandmother's kidney turned out to be a perfect match and Richard's body accepted it very well. Still, some caution was advised at first because the rejection process could set in at any time. The first two weeks were critical.

During this period it was apparent that the conflicts Richard had felt in relation to meeting his biological family had diminished. Now he was aware of strong support from both his families. He met his mother when she came to see him at the hospital after his surgery. His foster parents provided ongoing security. Richard had their name and the assurance of permanency in their home. His two foster sisters and foster brother also visited him.

Other relatives were introduced gradually. He especially enjoyed meeting new uncles whose youth and friendly bantering put him at ease. His grandmother, recovering at home from the removal of her kidney, asked that he call her each day. Her open, loving attitude, her good humor, and her understanding of Richard's feelings were appreciated by all who worked with her. She shared with them her feeling that this was "the best thing that ever happened to us. We have found something very wonderful."

As his recovery accelerated, Richard's positive outlook grew. His school arranged for tutoring. Learning became easier for him and his confidence in the future improved. His foster mother felt that his improved emotional response was almost as much a miracle as the success of the kidney transplant.

Remnants of anger remain to be reckoned with as this young man moves through adolescence into adulthood. The past will not be erased. The presence of his biological family will make it possible to explore the areas that he has previously dealt with only in fantasy or, sporadically, in therapy. The understanding of relatives is playing a vital role in his recovery from emotional as well as physical trauma.

The agencies remain a support system for both families and continue to share the goals of helping to strengthen and support all those involved in Richard's life. ■

*Although subsidized adoption legislation has been passed in the District of Columbia, medical authorities had advised the foster parents not to adopt him.

Workshops on Wheels Bring Training to the Day Care Door

by Pamela Mauk and Patrick L. Gogerty

Photos: Seattle Day Nursery

We are a nation ever more dependent on child care providers to oversee our children's growth. The percentage of single-parent families and households in which both parents work have risen dramatically in the last decade, resulting in increased demand for child care facilities. Unfortunately, programs to train and equip day care providers have not increased as rapidly. As a result, many caregivers have had no special training and lack the resources to provide positive, developmentally-oriented programs for youngsters.

In the Seattle, Washington, metropolitan area, where 14,000 children under age six have working mothers, Seattle Day Nursery—a United Way agency—has tackled this problem by bringing training literally to the doors of day care providers. Since 1976, through the agency's Early Education Mobile Resource Program, vans piloted by education specialists have been visiting caregivers in the city and surrounding suburban and rural areas, providing specialized training and support services to enhance caregivers' skills.

Beginning with one van in the inner city, the program has expanded to

Pamela Mauk, formerly with Seattle Day Nursery, Seattle, Wash., is staff assistant for development and public relations for the Ryther Child Center, Seattle. Patrick L. Gogerty is director of Seattle Day Nursery.

Gail Haynes, a Mobile Resource Unit staff member, works with a child in a family day care provider's home.

Photo: Seattle Day Nursery

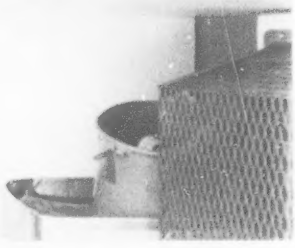


Photo: Tom Brownell, Seattle Post-Intelligencer

Above: Inside the van, MRU coordinator Margo Siegenthaler (right) shows a caregiver some of the items that can be borrowed. Opposite: Staff member Wayne Reinhardt discusses the program with a visitor from South Africa.

three vans visiting three counties. To date, 350 homes and centers have received training and resources, and about 85 day care homes and nine centers are added each year.

The workshops on wheels disseminate information, provide educational materials, books and art supplies and act as a liaison between Seattle Day Nursery and the wider child care community. The day care providers spend an hour and 15 minutes twice a month with a resource specialist while the children under their care are supervised by a mobile van assistant.

Accessibility is the program's most distinctive characteristic. Lack of child care training results most often from provider isolation, particularly in rural areas where transportation problems are common. In addition, day care providers often work a 10- to 12-hour day, leaving them little time or energy for taking classes at night. The van's mobility counters the caregiver's isolation—and both providers and children say they like the break in the daily routine. One caregiver calls it "an outrageous program. . .the kids always look forward to van days. They love the things they do." Another provider looks forward to the van's visit because it delivers "emotional support and advice, the chance to freely discuss everything with someone who really cares about children. This enables me to provide better care."

The Training Program

Training for workers in day care centers is accomplished through biweekly workshops while for family day care home providers, one-to-one consultation is used.

The program for family day care providers follows a 20-session curriculum. Each 75-minute session includes four elements: discussion of the caregiver's concerns and a topic of the day presented by the trainer (the time spent for each segment varies, depending on the caregiver's needs); discussion of a specific activity (5 to 10 minutes); selection from the van's toys and resource materials for use in the day care home (15 minutes); and modeling of skills by the specialist (10 minutes).

The van assistant first takes charge of the children, reading to them or telling a story, singing songs, conducting art activities or playing active games. Relieved of her duties, the caregiver meets in the van with the

Photo: Seattle Day Nursery

Staff member Beverly Forsythe involves children in a building activity in a caregiver's home.

resource specialist. There, in a comfortable, quiet environment, the caregiver raises specific concerns—about a particular child or parent, for example, or about an activity that did not work.

These conversations provide a "great sounding board, helping me to get a better perspective on my job," explains one caregiver. Another mentioned her delight at having an opportunity to "air problems with a caring professional." Problems discussed range from the mundane to the serious: A provider may complain that a child only eats peanut butter sandwiches, or she may raise her suspicions that a child has been abused.

Caregivers' questions often involve child development: Is this child normal? Why is she different? Answers to broader concerns about children are not delivered prepackaged. Rather, over a year's time, a problem-solving approach is stressed.

This emphasis recognizes that there are many ways to handle child care problems. A great benefit of a program which meets 20 times is that a variety of methods can be tested and the results analyzed. The one-to-one instruction also enables providers to receive positive feedback. And since the training takes place at the day care home itself, methods can be immediately adapted for specific situations.

The specialist may also refer the provider to a variety of resources—such as medical, legal and recreational organizations—in the community. Or the caregiver might ask the specialist to meet with parents or to arrange story hours and special classes. For example, one mother was having problems raising her two boys. "My oldest boy is advanced for his age," she noted, "and it's hard to get him interested in most activities that others in his age group enjoy." The specialist helped him to enroll in a class on model rocketry at the Seattle Science Center, and his behavior improved markedly.

A variety of child care issues are also addressed when the specialist and provider focus on the prearranged discussion topic for the session. Although the Mobile Resource Program (MRP) has developed an outline of suggested topics, the curriculum is planned for individual instruction, based on each provider's needs, since the caregivers' skills, the type of home and the ages of the children served vary greatly. The specialist gives the provider printed information on the topics, which include guidance and discipline, relationships with parents,

activities for children, health and safety practices, child growth and development, working with children with special needs, behavior problems, nutrition, recordkeeping and other business practices.

Most of these printed handouts are derived from magazine articles; many are written by MRP specialists and some are reprinted with permission from standard texts. They are regularly supplemented and revised by staff members. The materials are considered a resource to which providers may turn to plan their own curriculum. By the end of the course, the providers have accumulated a reference library of some 350 pages.

After the discussion period, the specialist teaches a specific activity involving science, music, numbers or making toys from "throw-away" items. Language development and systems of classification are emphasized and the objective of each activity clearly identified.

The time spent in selecting toys and resources from the van is a popular part of the program, particularly among those new to day care. Providers may borrow audio-visual equipment, easels, balance beams, puzzles and a host of toys. Caregivers often lack funds or storage space, and some may also lack experience in purchasing toys and educational equipment. One provider had given up buying anything because "all the little pieces get lost or broken." A loan from the Mobile Resource Van allows caregivers time to examine equipment and to test the durability of a toy, as well as its appeal to children or its appropriateness for a particular age group. Many objects which would never be purchased because of space limitations or expense can enliven the day care program for the period of the loan. All of the providers claim the new equipment enhances the quality of their care.

The topics of the workshops for day care center workers (determined by the center) include child development, curriculum planning, center management, activities with children, child abuse, sex education and discipline. Demonstrations of materials are emphasized. As with day care homes, the needs of day care centers vary greatly, and individual sessions with a center's director are often planned to determine how best the resource van can assist the program.

Following the 60-minute workshop in the van, the workers and specialist return to the center, where the van assistant has been in charge of the children. The specialist presents a story or song or joins in a project in progress while the caregivers both observe and participate. The specialist introduces children and providers to new activities—many caregivers have never before molded playdough or dribbled finger paints—and also models effective skills in working with children. In one center, for example, a child care worker was so anxious to maintain an extremely professional facade that she had refused to participate in activities with the children. However, seeing that the trainer could "play" with the children without relinquishing her role as a teacher, the caregiver gained the confidence to join in their games and activities.

Classroom activities are not specifically geared to the workshop topic. However, through modeling, discussions are often reinforced.

By spending time in the center, the specialist also becomes familiar with individual children (aided as well by discussions with the van assistant), and by actually using the space he or she is able to note any problems and offer suggestions on improving the environment—discouraging the use of television as a constant background noise, placing pictures at a child's eye level and storing toys on shelves instead of in boxes, for example.

Response to the Program

At the end of the course, providers are asked to complete a survey evaluating the Mobile Resource Program. Ninety-two percent of the caregivers surveyed at the end of the first year stated that their job had been made easier as a result of the visiting van.

"The topics and handouts were very valuable," said one. "When a parent asked for my help with a problem, I was able to give her information on it. I used the handouts constantly." Another liked "the environmental pictures shown of different day care homes and what they did with their homes."

Providers listed many materials they have made from the specialist's instructions: flannel story-telling boards, puppets, xylophones, mobiles, collages, bean-bag toss games, block prints, indoor hopscotch mats—all of which broaden the scope of activities they conduct in the home.

Caregivers cited the new ideas and the confidence they gained as important factors in making their job easier. One day care mother mentioned the help she received in handling two problems—stuttering and bedwetting—typical of her children's age group.

Caregivers' relations with parents also change as a result of the training. Often providers enter the day care field little realizing what they're getting into, with no business experience, knowing only that they like children. Many leave the field exhausted from hassling with parents. Many providers have indicated that, as a result of the training, they have become more comfortable handling business matters and more assertive in setting limits with parents.

It is important to note that the Mobile Resource Program is very much a 2-way exchange of information. Specialists learn much about activities and the behavior of children from providers. And because there is an enormous range of skill levels within the day care field, there is great variety as to what providers receive from the program. However, their comments indicate that for all, the training delivers new or renewed confidence and pride in being members of an important profession. One caregiver expressed it this way: "It makes me feel more professional knowing I warrant this expert attention and effort." Another said, "It was an encouragement for me to stay in day care."

The Participants

The Mobile Resource Program's services are provided on a first-come, first-served basis to caregivers who meet the following criteria:

(Continued on page 35)

Child Care At Conferences:

A Family Approach

by Julie Carvalho

On a veranda of the Washington Hilton, Gary, Randy and Michael splashed themselves and their surroundings with water from a water play table. The boys, aged 9 to 12, seemed oblivious to the sweltering August heat or the newness of their friendships. Behind the sliding doors, several younger children were sitting around child-size tables with a teacher, engrossed in art, puzzles and a typewriter. Next door, five toddlers were deciding whether to doze off on their mats, while three infants were asleep in cribs and four were being fed, changed or amused by nurses.

After several years' discussion and a year's planning by Federally Employed Women (F.E.W.), a child care space for our 1980 national training conference had become a reality.

Using various arrangements, a growing number of national organizations are providing child care at conference sites. Organizations have found that they can attract more parents, including more single parents and members of minority groups, if child care is available during meetings. One advantage of this increased participation is that the nature of discussion on human issues may broaden if people who are not "childfree" contribute their perspective.

In such human service organizations as the American Psychological Association (APA), both parents may be members and wish to bring their children with them if high quality child care is provided. Parents have reported that they can enjoy the meetings without undue worry, expense or strain. With child care available, more women can enter traditionally male fields where frequent out-of-town meetings are required.

Children can learn from the travel and meetings, be near their parents and meet children in similar situations—advantages that hotel "babysitting" referrals can't match. Adelle Cox Convention Services and Consultants, Inc., which runs children's hospitality centers for APA and other organizations, has cared for some of the same children from infancy through their adolescent years, as their parents attended annual conferences in different cities. With such continuity, children may look forward to seeing the same staff and youngsters again.[1] Hotels, too, may prefer such family-oriented conferences, one hotel convention director asserts.

As successful as many sites have been, others have foundered because they did not consider the ways in which child care at conferences differs from conventional child care. For example, the children who come to these centers may be weary from plane or car trips. They are exposed to strange people and surroundings, with no gradual introduction permitted. Center staff members do not have time to become familiar with a child's personality and habits over a few months; they must adjust to dozens of new children immediately. In addition, parents and children may have erratic schedules, including evening sessions for parents and odd meal hours. Some parents may also have special expectations for this kind of child care—one mother was disappointed with a conference center evening program for older children of movies, stories and simple food; she had expected a tour of the hotel and gourmet dishes for her youngsters.

Julie Carvalho, an evaluation specialist in the Office for Civil Rights, DHHS, is the mother of five children. She chaired the child care committee for the 1980 F.E.W. National Training Program and serves as the F.E.W. child care specialist.

Once a conference is planned, the organization must determine whether there is enough interest in and need for child care among the members. If so, the center program should be publicized early; families who might bring their children often need several months' lead time and budgeting to decide whether and how to arrange it.

Costs

The organization must decide how much of the cost it is willing to share. It might pick up the whole cost, subsidize part of it, or offer the care at cost, in which case payments could be made according to a flat fixed fee or an hourly rate. If a center attracts even 20 parents who might not otherwise attend the conference and they fill vacancies in workshops, their registration fees can help pay for the site. Because infant care is very expensive and there are other opportunities for adolescents, an organization may decide to limit the ages of eligible children at either end of the age scale. In any case, a genuine commitment to providing professional child care is needed before any decision to offer such care is made. Provision of care at a conference does open an organization to some risk. And from an attending family's point of view, a center promised but then unavailable can result in changed plans, at best, or makeshift care at worst.

Depending upon the features an organization chooses to include in its child care center, the cost per child will probably range from $5.00 to $15.00 per day.

Planning

A workplan and tentative budget must be developed early as part of the conference planning. Information obtained from early registrants on age and other characteristics of the children to be enrolled, and the length of time they will be in the center, forms the basis for many of the decisions needed. The organization should decide in advance whether the center site will be able to accommodate all the children who show up, only those who have been preregistered, or a limited number of late registrants as well, on a space-available basis.

The organization should appoint a committee chairperson or co-chairpersons with a demonstrated interest and background in child care—and with no other responsibilities for the conference. Enlisting the services of a consultant with specialized experience in arranging child care sites may be a useful investment to avoid any waste of time and funds. Our consultant, Carol Rudolph, was able to identify many resources for us and to anticipate needs that even a teacher or parent might not.[2]

Location

Early in the planning, a child development specialist should visit possible sites to decide on those most appropriate. The organization may assign the committee space at one of its hotels, or the committee can negotiate with the hotel's convention staff for suitable space and equipment. However, some hotels may back off at this point because they are not familiar with child care centers or consider them too much trouble. After we had had a series of disappointments regarding arrangements made with the hotel we had announced for the F.E.W. site—and an increasing number of infants had been registered for attendance—we switched to another hotel. It was less conveniently located but its staff was interested in housing a family activity and offered us groundfloor rooms suitable for use with the babies and other children.

Other sites to consider are local child care centers, with whom the organization or individual parents may arrange for child care. However, most centers close around 6 p.m., a factor which would limit parents' conference participation.

Insurance

Insurance can be arranged with the carrier for the organization, the conference or the hotel, or it can be arranged independently, which is far more expensive. Parents may need to sign statements absolving the organization and hotel from responsibility (assuming that reasonable care is given) if insurance is to be obtained at an affordable cost. The carrier may stipulate center location, caregiver-child ratios and other requirements in order to underwrite a group site. Local ordinances do not usually affect the operation of short-term centers, but their requirements should be checked.

Center Activities

After the committee has determined the ages and other characteristics of children likely to attend

the child care center, it can develop a schedule of activities. Because the children may initially be tired, there should be flexible provision for rest and quiet activities. Enough space for children to exercise is also needed.

Field trips for older children should be coordinated with a local resident familiar with local transportation and the other logistics of moving children safely.

In 1981, the F.E.W. conference in Indianapolis featured a chartered bus trip to the zoo, a public bus trip to the Indianapolis Children's Museum, and walks to historic areas near the conference. Videotapes of programs for children were also available on-site for children who wished to stay at the center.

A separate quiet room at the child care center is useful so that energetic youngsters do not keep the tired ones awake. Depending on the distribution of children and their own inclinations, center planners may want to separate children by age groups or encourage some mingling, with older ones caring for the younger ones. Faced with 1,000 children for an evening, while attendees at an insurance conference listened to an address by the president, Adelle Cox set up separate theme parties for each of several age groups among the children.

Staff

Probably the largest portion of the center budget will be used to pay center staff members. The staff should consist of professionals whose training is appropriate to the ages of the children enrolled. A contingent of persons available on-call should also be arranged for—if the number of children attending is larger than anticipated or in case some staff members don't show. Volunteers, including the elderly, teenagers and older children, can fill gaps if they are properly briefed and supervised. The F.E.W. program in Washington, D.C. relied on a nursing agency and several teachers, teenagers, and F.E.W. volunteers to staff the child care center. We were unsuccessful in interesting local volunteer agencies, schools or conference participants to donate a few hours, even with the offer of a certificate or free workshops. Since a large percentage of volunteers do not show in such an activity, a program should not count on them in planning the staff/child ratio.

The Indianapolis F.E.W. child care center drew staff members from a local day care center and from relatives of committee members who were skilled with children. (Some of them were men.) To find appropriate child care workers, Adelle Cox asks a registered nurse to select nurses from a children's hospital or similar institution in the convention city.

In selecting center staff members, the child care committee should look for a professional who will take the initiative in playing with small children, rather than one who will just check the children physically, as some nurses used to home assignments have done at conference sites.

Some hotels have lists of bonded "sitters" who could be checked for use as back-up workers.

An organization may urge the use of nonprofessionals as the basic staff to reduce costs. One organization official told me that "Mothers don't have to be registered nurses or certified teachers before they have children." I responded that the needs of children in an "instant center" are very special, while parents have time to get to know their children—usually one at a time. Cutting costs on staff may be counterproductive if it results in poor care which jeopardizes the children's health and safety—and the organization's reputation. Experienced, skilled parents and professionals can best handle an emergency with sketchy information on a child, or discover the cause of a strange child's distress. On the other hand, good staff members can help save expenses, by their ability to use simple materials for games and projects, for example.

Safety and Health

If an organization is lucky, the worst that happens is that a child drinks the left-over coffee of a careless staff member. On the other hand, it may care for a child who has an epileptic seizure even though the parent had not indicated the child was susceptible. As in other child care, a trained child care staff and preparation for possible emergencies are the keys in avoiding disaster.

An organization may decide to have parents bring records of their children's shots, fill out a physical examination form and sign a medical release. Or it could ask the parents to answer some basic questions, certify their child's current health and sign a release.

Any medication to be given a child should be handled with the same procedures a regular center would use, but more concern for identifying each child and his or her supplies, of course, will be needed. All instructions from children's medical records should be posted, along with emergency procedures and verified phone numbers. Each staff member should be given a copy of the center's operations schedule and other information they can refer to. For our center, we asked a consultant to provide written information on how to handle children's feelings about separation in the center.

A "No Smoking" rule may need enforcement, especially with volunteers who feel they can do as they wish since they're not being paid.

Written agreements on first aid procedures, any back-up activities of the hotel and use of local emergency rooms will be necessary. The insurance company and the hotel may have instructions to give on evacuation—a drill with the chief center staff members for each period is advisable. Special procedures may also need to be planned for any walks or trips to be taken by the children. Because you won't know the children's habits, it is more important than usual to have assignments for hand-holding and head-counting.

Depending on the location of the center, some monitoring devices for the children will be needed. Adelle Cox requires a sign-in and sign-out procedure before a child can enter or leave the center, and parents' signatures are compared with those on the registration forms. The firm also posts monitors in the halls to prevent children from wandering away or strangers from entering.

Schedules for parents and children should also be readily available at the center.

Some parents may resist the forms and procedures, on the grounds that they will not be separated from their children for long periods. However, this is one area that requires cooperation. For instance, after reading the remarks of parents who preregistered, our consultant and I were able to identify each of the children as they began playing. Because we knew something about them—whether they were timid or aggressive, for example, we could head off some problems and deal with others. In one case, we asked several staff members to console a toddler known to "want his mummy"; when his mother returned, he pointed to the large woman who had been successful and said, "Mummy, I want *that*."

Food

For our conference, we solicited and received vouchers from local food stores to help develop a low-budget but nutritious menu. Every hour and a half, to cover each of the children entering or leaving, we served a nutritious meal or snack. Only one child was known to have overindulged—most of them were too busy with activities.

Because the temperature had hit 103° in Washington, D.C. that week, we avoided bringing in milk and felt that even the hotel milk might not sit well with kids. Lemonade and less spoilable finger foods were avidly eaten each day. A home casserole was brought in frozen and warmed on a separate burner we'd bought. Mothers of infants were asked to bring and prepare their children's bottles.

If preparing food at the center is difficult, parents can be asked to bring in food for their child. Or the organization can contract with the hotel for meals or purchase food from local restaurants or order room service—in order of increasing expense. Whatever procedure is used, a method for reminding staff members of children's allergies and special food needs is necessary.

Equipment and Supplies

The hotel is the first source of such equipment as refrigerators and cribs, and of such supplies as linens, since there's no problem with delivery. At our meetings, the children enjoyed using such conference equipment as overhead projectors, movie projectors and tape recorders; but the machines had to be reserved and funds alloted for them weeks ahead.

The local Convention Bureau or Chamber of Commerce may have sources for renting cribs, playpens and feeding chairs. Some rental services will deliver and pick up items, and supply more when needed. Local child care or church facilities may also lend equipment and toys, but the time and transportation involved in dealing with them may exceed the cost of renting. We used the public library to borrow movies, records and books for the center. (We had to replace a few taken home by the children.) Videotape playback machines and cassettes can be rented for a week or weekend, or a parent may oblige.

In Washington, D.C., we obtained specialized furniture and toys from a clinic at nearby Georgetown University Hospital. Children's supply firms may also send equipment on consignment for sale to parents or local centers after the conference; one corporation sent us several boxes of toys and mats which were eagerly bought afterwards. Stepstools and potty seat converters were brought by us for each of the bathrooms.

If an organization plans to have child care centers at several conferences, it may wish to invest in permanent equipment or toys, which could be transported to each conference city.

Publicity and Preregistration

The first link in the chain is adequate notice to parents who may wish to use the child care center. Enough information should be provided to enable parents to make a decision in advance. Preregistration of at least some of the children gives the staff some idea of the characteristics of the group and the personalities of individual children. Sufficient lead time is necessary to have initial notices on the center included in the mailing of conference materials. Later, a separate mailing to parents requesting information is less likely to get lost in the shuffle of papers.

Parents' Roles

Parents' responses to the center, whether they're paying for the child care or not, will range from offers to help to resistance in providing information and supplies for their child. During one of our conferences, one mother volunteered to spell the director during the long evening. In contrast, another had to be tracked down to provide basic information on

her child. A third mother brought equipment and toys to be shared at the center, while another sent her children over in a cab with no information about them except that provided by the oldest, a 12-year-old.

As in routine child care, frequent interchanges with parents prevent major problems. We sent parents a welcoming letter, specific center information and news of any changes in plans. The staff could accommodate the reasonable requests of some parents but insisted that others abide by the rule to prepare their own infant's bottles.

If any slip-up occurs, acknowledging it to the parent should ease the situation.

Providing information on children was one of our goals for our conference child care center. To decorate the walls, we hung International Year of the Child posters. A group of books on childrearing and booklets on parents' resources were available in a parents' corner.

A conference child care center also offers an opportunity for guidance to parents seeking it. At one site, a father who had long been puzzled by his son's behavior was told that we had noticed several symptoms of hyperactivity and we suggested that he discuss this with his pediatrician.

We included our recommendations on local trips for children in one of our mailings and the conference magazine also had an extensive listing of them. However, we urged parents to spend some time each day with their children rather than just arrange tours for them. (A treat for my daughters in Indianapolis was a luncheon where Congresswoman Shirley Chisholm spoke, while my son enjoyed a song fest.)

Evaluation and Replanning

Parents were candid in reporting what they liked or disliked about features of our center. (Fortunately, more of the former was reported.) Open-ended questions sought specific information on how parents and children had felt about the center before, during and after the conference.

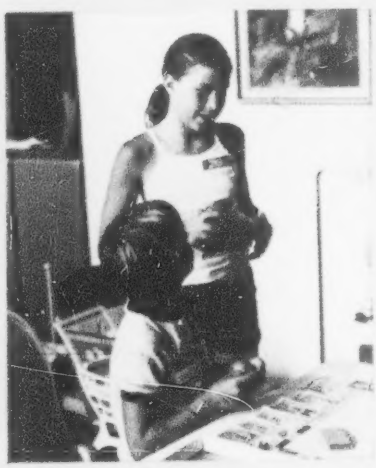
We also discovered we had learned a surprising amount about each child in a few days and we conveyed to the parents our enjoyment of their children.

We held a briefing session with our chief child care staff members to decide what we would do differently next time and we prepared a set of recommendations for the conference board. The detailed expense vouchers we had were useful in budgeting for the next conference. The best formal evaluation procedures, however, may not be as useful as the observations of parents and children. When one 6-year-old visiting the engaging Air and Space Museum told her father she'd rather come back to the F.E.W. center "to play games again with my new friend," we knew we had achieved success.[3]

Recommendations

It is likely that more children will be accompanying their parents during conference meetings and other adult activities in the coming years. Child development professionals can help this be a source of growth for those involved. Based on the experiences of several organizations which have attempted child care at conferences and training sessions, seven recommendations have emerged:

- The organization must have a firm commitment to quality child care and, once the center is announced, help the child care committee overcome problems and obstacles.
- The committee responsible for operating the child care center needs to have specialized expertise in group child care.
- Child care should be made part of the conference plans from the outset and its availability publicized early.
- The director of the child care center must clarify expectations of the parents, organization, staff and hotel, and he or she should provide information to insure understanding of the actual arrangements.
- Before the conference, the director should obtain as much information as possible on the children to be enrolled, insure parents' cooperation when needed and, when appropriate, provide feedback to parents.
- A mix of nurses, teachers and other professionals should staff the center. Gaps in staffing can be filled by volunteers of various ages and backgrounds. Both groups of caretakers should be briefed before the conference.
- The committee should establish stringent requirements to maintain quality care and it should develop back-up resources for all arrangements.



As my 12-year-old son and I were lugging heavy equipment to the Hilton Hotel in the heat of the July F.E.W. meeting, we asked each other whether this level of work was needed for child care. The next year, as I watched a parent remove an overstimulated youngster from a conference activity, I wondered whether this new social movement was helpful. But then, as the children were leaving, I heard them talk about the men, women and children they'd met, and the places they'd enjoyed with their parents. And when I heard them ask their parents, "Can we go with you next year?" I knew I had the answer. ■

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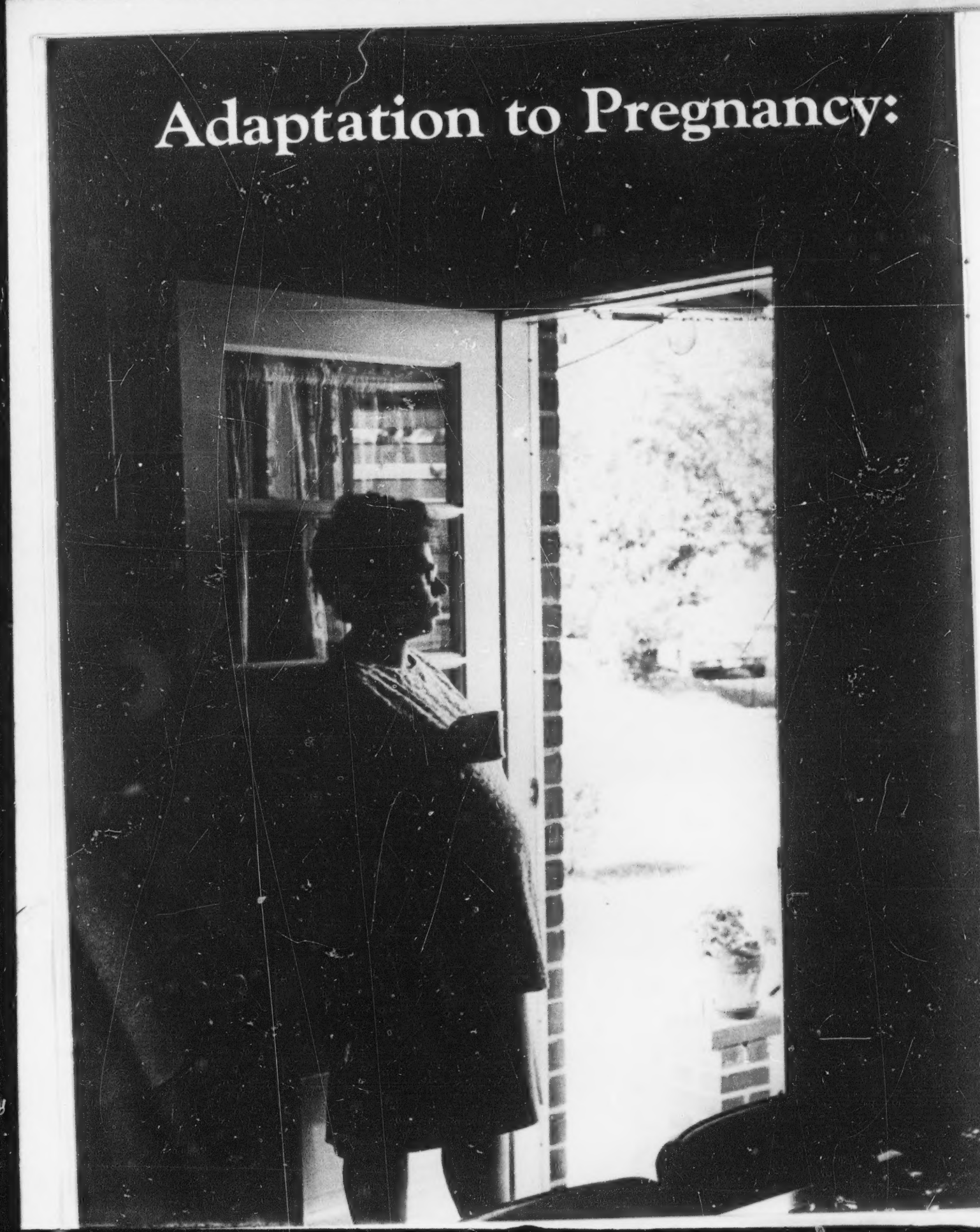
[1]Adelle Cox, Convention Services and Consultants, Inc., 321 N.W. 186th Street, Miami, Fla. 33169.

[2]Carol Rudolph, Child Care Management Resources, 5620 Greentree Road, Bethesda, Md. 20817.

[3]Copies of forms, correspondence and other materials used in the planning and operation of the 1980 F.E.W. child care center are available at $2.00 (for the cost of duplication and mailing) from Julie Carvalho, 11668 Mediterranean Court, Reston, Va. 22090.

Adaptation to Pregnancy:



Some Implications For Individual And Family Mental Health

by Deborah Valentine

Pregnancy is becoming acknowledged as a critical point in the psychological life of the expectant parent and the family system. No longer is it considered merely a time of waiting and psychological moratorium.

The means by which individuals cope, adapt and confront issues raised during pregnancy impact on the family as a unit and on each of its members. A review of the literature on the subject helps identify factors during pregnancy which may affect the mental health of parents, families and infants.

This article reviews the literature on pregnancy and its impact on postpartum adjustment in the following four areas: pregnancy as a normative crisis period; pregnancy as a developmental process (including the developmental tasks of both pregnant women and expectant fathers); the impact on the marital relationship (including family violence issues); and implications for prevention and intervention during pregnancy.

The Psychological Process

The experience of pregnancy is no longer viewed as a static, passive waiting period. Research suggests, in fact, that the variables most predictive of postpartum success are intrapsychic in nature.[1] Two theoretical orientations have surfaced regarding the experience of pregnancy. The first is that pregnancy is a transition or normative crisis period for individuals and the family. The second orientation views pregnancy as part of the developmental process of individuals, with corresponding developmental tasks.

Transition or Normative Crisis Period. Normative lifespan stress for the family has been the topic of discussion for a number of authors. Rhona Rapoport focused on critical transition points in normal family development.[2] These periods lead to resolution and growth or to maladaption and threat to the integrity of the family unit, she found, stating that "the way these normal crises or status transitions are handled or coped with will affect outcome—both in terms of mental health of the individuals and in terms of the enduring family relationship."

> Knowledge of the developmental tasks of pregnancy can be utilized to provide preventive services to expectant parents.

Critical role transitions occur in most families and serve as a demarcation for stages in the family life cycle. There is some indication that the acquisition of roles is more stressful than the loss of roles and a number of researchers and theorists view pregnancy as just such a normative crisis. For instance, Gerald Caplan writes:

"As in any crisis, preventive intervention during the period of upset has a greater effect in terms of influencing the attitudes of the participants. Minimal intervention during pregnancy is often remarkably effective in promoting and safeguarding not only the relationship to her future child, but also the other relationships among members of the family, which are so important for their mental health."[3]

Researchers have begun to investigate the notion of "pile-up" of family life events and stressors. A family may be more vulnerable to crisis with increased experiences of both normative and non-normative life events or life changes. Cindy Williams et al., for example, reported that in their study of 23 mothers of premature infants and 23 mothers of full-term infants, respondents with medical problems reported higher life change unit scores during pregnancy.[4] In a study of low-income patients, R. Gorsuch and M. Key found that life stress occurring in the six months prior to the birth of an infant was significantly related to obstetrical complications.[5] Three other researchers (Gordon, Kapostins and Gordon) found that the more stresses, past and present, the more postpartum difficulty for women was seen.[6]

Stresses during pregnancy which have been suggested as increasing emotional or medical risks include the following: financial strain, marital disharmony, social isolation of the nuclear family and such emotional strains as unwanted pregnancies, illness or the death of a family member, as well as such long-term stress as that resulting from racism or poverty.

W. Kennell, D. Voos and M. Klaus suggest that any stress which "leaves the mother feeling unloved or unsupported or causes her concern about the health and survival of her baby or herself may delay preparation for the infant and retard bond formation."[7]

Deborah Valentine is a Program Associate, Region VI Resource Center on Child Abuse and Neglect, Austin, Texas, and a teacher and doctoral candidate in social work at the University of Texas, Austin.

Gordon et al. list 14 stress factors they used to predict the likelihood of postpartum difficulties:[8]

- ☐ A first birth.
- ☐ No relatives available for help with baby care.
- ☐ Complications of pregnancy in family history.
- ☐ Husband's father dead.
- ☐ Wife's mother dead.
- ☐ Wife ill apart from pregnancy.
- ☐ Wife ill during pregnancy.
- ☐ Wife's education higher than her parents'.
- ☐ Husband's education higher than his parents'.
- ☐ Wife's education incomplete.
- ☐ Husband's occupation higher than his parents'.
- ☐ Husband's occupation higher than his wife's parents.
- ☐ Husband often away from home.
- ☐ Wife has had no previous experience with babies.

These researchers report that of 95 women with higher scores (five or more out of the 14 stress factors), 40 percent developed emotional difficulties at six weeks and 29 percent continued to have trouble after six months. Of the 211 women with lower scores (less than four out of 14), only 6 percent had emotional difficulties and these tended to last for fewer than six months.

The stress and crisis experienced by an expectant mother is regarded by Caplan as a preventable psychological emergency.[9] He is convinced that it is possible to predict the approximate type of relationship a mother will have with her newborn if the pregnant woman's psychological state is evaluated, and he suggests that preventive intervention can facilitate successful parental adjustment and healthier infant care. G. L. Bibring also views pregnancy as a major turning point in the life of a woman—he sees it as representing a normal crisis—and he concluded that the outcome of this crisis has a profound effect on the early mother-child relationship.[10]

Some research is available which suggests that expectant fathers go through an upheaval similar to that of mothers. M. Zaslow noted that while 89 percent of women in a study of new parents reported some symptoms traditionally associated with postpartum depression, 62 percent of the fathers had similar symptoms.[11]

Human embryo, 56 days old. Photo: Chester F. Reather, from the exhibition, "Biological Photography," circulated by the Smithsonian Institution Traveling Exhibition Service.

> It may be that the response of mothers to their infants is partially dependent on the nature of the marital relationship and the propensity of their spouses to assist and support them.

In a study of child abuse, Margaret Lynch reported six factors that were overrepresented during the periods of pregnancy and early parenthood in relation to an abused child, as compared to their unabused siblings:[12]

- ☐ An abnormal pregnancy or an abnormal labor and delivery.
- ☐ Neonatal separation or other separations during the first six months postpartum.
- ☐ Illness in the infant during the first year of life.
- ☐ Illness in the mother during the first year of life.

She concludes that treatment of parents during pregnancy, the perinatal period and the child's early infancy may be optimal times for the prevention of child abuse.

Although in many ways the stress factors associated with difficult adjustment and child abuse are not preventable, it is crucial for individuals in the service professions to be alert to the existence of stress factors in expectant parents. Recognizing the urgent needs of these higher risk parents can permit early identification, appropriate intervention and primary prevention of possible serious behavioral and relational disturbances.

The Developmental Process

The experience of pregnancy has found a place within the framework of the developmental course of the human life cycle. Researchers suggest that there is a predictability and conformity of psychological processes characteristically experienced by expectant parents. It has been suggested that the psychological process can be delineated into specific developmental tasks for both expectant mothers and fathers. Breaking down the psychological process of pregnancy into developmental tasks implies that success or failure in accomplishing these tasks will affect future individual task accomplishment. R. J. Havighurst says that a "developmental task is a task which arises at or about a certain period in the life of an individual, successful achievement of which leads to his happiness and to success with later tasks, while failure leads to unhappiness in the individual, disapproval by society and difficulty with later tasks."[13] Thus, the assumption that pregnancy can be viewed as a series of developmental tasks implies that the way in which these are confronted will be predictive of adaptation to future adult and parental roles.

After reviewing the literature, I concluded that for expectant parents the overriding psychological objective during pregnancy is the development and acceptance of a coherent sense of self as parent, before actually assuming parental responsibilities. I have identified four distinct developmental tasks for both the pregnant woman and the expectant father.[14]

Developmental Tasks of the Pregnant Woman.

- ☐ Development of an emotional attachment to the fetus.
- ☐ Differentiation of self from fetus.
- ☐ Acceptance and resolution of the relationship with her own mother.
- ☐ Resolution of dependency issues.

Developmental Tasks of the Expectant Father.

- ☐ Acceptance of the pregnancy and attachment to the fetus.
- ☐ Evaluation of the practical issues and financial responsibilities.
- ☐ Acceptance and resolution of the relationship with his own father.
- ☐ Resolution of dependency issues.

It is interesting to note the similarity of developmental tasks between expectant mothers and fathers. But although these tasks are confronted simultaneously by expectant couples, there is often little complementarity and the partnership may be riddled with conflict.

Research has substantiated the assumption that successful accomplishment of these tasks is predictive of postpartum adaptation. M. Leifer found that the degree of involvement with the fetus by the expectant mother is predictive of later maternal feelings toward the new infant.[15] J. W. Ballou's research suggests that if a pregnant woman's relationship with her mother is problematic, her relationship with her child may be adversely affected.[16] The Munroes suggest that mild psychosomatic pregnancy symptoms among expectant fathers ("couvade syndrome") may be an adaptive involvement with the pregnancy and the fetus in that it is associated with strong involvement in infant caretaking.[17] In addition, T. Benedek asserts that dealing with the identification relationship and perception of an expectant father's own father will influence his ability to be a tender and loving father.[18]

Dr. T. Berry Brazelton considers the turbulent, emotional changes during pregnancy a preparatory period for new attachments and views the turmoil as a positive force for the mother's adjustment to providing an individualized environment for the infant.[19] Certain behavior, however, suggests rejection of the pregnancy and possible rejection of the infant. Such behavior can include a mother's preoccupation with her physical appearance, negative self-perception, excessive emotional withdrawal, excessive physical complaints, absence of any response to quickening and lack of preparation during the last trimester.[20]

I would suggest that knowledge of the developmental tasks of pregnancy can be utilized to provide preventive services to expectant parents. These can facilitate the process of successfully confronting the developmental tasks of pregnancy and thereby enhance future individual and family growth and happiness.

The Marital Relationship

The relationship between marital partners is undeniably a most important aspect of the quality of family life. Virginia Satir states that the "marital relationship is the axis around which other family relationships are formed and maintained and a successful relationship tends to produce successful parenting and family life."[21] This relationship has been a topic of investigation by researchers interested in the transition to parenthood. Generally, results suggest that those couples whose marriage is stronger tend to experience less difficulty when their child is born. Data collection about the experience of pregnancy, however, is primarily retrospective.

Investigators studying marital relationships over the course of the family life cycle suggest that there is a decrease in marital satisfaction after the birth of a couple's first child. Once again, however, the data upon which their studies are based were not collected during the pregnancy period. One exception is a study conducted by Meyerowitz and Feldman who interviewed 400 primaparous couples three times: in the fifth month of pregnancy, five weeks after delivery and five months after delivery.[22] They reported a decline in marital satisfaction during pregnancy. One month after the child was born the relationship during pregnancy was recalled as a low point and not expected to be matched again. The quality and the intensity of the psychological work required during pregnancy increase the stress of married life. The similarity of developmental tasks between expectant mothers and fathers might indicate the possibility for complementary task accomplishment in such a manner that couples would mutually assist

and support one another. Not only would this method facilitate individual task accomplishment but it would also strengthen marital communication and adjustment.

The quality and the intensity of the psychological work required during pregnancy increase the stress of married life.

Several studies have looked at the marital relationship during pregnancy in relation to postpartum adjustment. F. K. Grossman et al. reported that the "quality of the marriage may be one of the most important dimensions influencing both partners' experience of adaptation to pregnancy, childbirth and early parenting."[23] They also found that aspects of the marital dimension proved to be one of the two strongest predictors of the woman's adaptation. "Women who felt more positive about their marriages felt less anxious and depressed in late pregnancy, at two months and at one year postpartum. They had fewer symptoms during the pregnancy and were substantially better adapted at the time of childbirth than women less pleased with their marriages."

Other researchers have found that couples with a good marital relationship before the birth of their child had little postpartum difficulty and that those couples with poor marital adjustment were more likely to experience postpartum depressions and more frequent complications during pregnancy.

P. M. Sherefsky and L. J. Yarrow found that the overall marital adjustment of a couple was strongly related to a variety of measures of maternal adaptation, suggesting that the quality of the marriage relationship affects the quality of parenting as well as individual adjustment.[24] This finding was confirmed by C. Feiring and J. Taylor, who reported that the emotional involvement of mothers with infants is related to the extent with which they report receiving emotional support from husbands during this transition to parenthood.[25] It may be that the response of mothers to their infants is partially dependent on the nature of the marital relationship and the propensity of their spouses to assist and support them.

Since the marital relationship seems to have a significant impact on the successful adaptation of both parents during pregnancy and early parenting, and on the parents' involvement with their infant, it would be negligent to ignore current documentation of physical violence during pregnancy. R. J. Gelles suggests that "violence during pregnancy is much more common than anyone has suspected."[26] Of 80 families interviewed by him, over one-half reported incidents of family violence and approximately 10 percent of the total sample reported incidents of violence while the wife was pregnant. Gelles asserts that "locating a family where a pregnant wife has been assaulted could serve as an indicator of the family's use of physical aggression as a response to stress and the likelihood of future occurrences of violence to the child."

Implications For Prevention

Recognition of the importance of the successful management of the psychological processes during pregnancy and the marital relationship should alert medical and mental health professionals and educators to the emotional needs of expectant parents.

At least two main factors contribute to my belief that the period of pregnancy is an optimal time in which to provide treatment, emotional support, education and preventive services to expectant parents. First, observation and research has suggested that pregnancy and childbirth are times when individuals tend to be particularly open about their feelings and eager to share their concerns and experiences. Secondly, most expectant mothers are readily accessible for mass intervention programs when they seek prenatal care or delivery at a hospital. Ray Helfer states that pregnant women coming for prenatal care to medical offices, clinics and hospitals would be a most accessible group for early screening. "When parents are identified to be in the high risk category," he says, "they must be *offered* an intervention program to assist the mother, her baby, and mate with a learning experience to improve upon their childrearing capabilities" and to facilitate individual growth and family development.[27]

In this light, there are at least four means by which postpartum difficulty could be prevented and the quality of individual and family life enhanced. First, medical personnel, mental health workers and family life educators could expand on the services to expectant parents that are already in existence. Classes on prepared childbirth, breastfeeding, parenting and infant development have been well received and utilized as a routine part of pregnancy care. Expansion of these services could begin in the first trimester of pregnancy and might include information pointing out the problems, social stress and psychological issues likely to arise during pregnancy. Since expectant parents would be made aware of these factors they might be better able to cope with the stresses and changes posed. This aspect of service might take the form of an education/support group model offering parents an opportunity to share concerns and discuss changes and psychological issues.

Classes on prepared childbirth, breastfeeding, parenting and infant development have been well received and utilized as a routine part of pregnancy care.

A second means of providing preventive services would involve alerting professionals to the need for referring expectant parents for counseling. B. Liebenberg, who provided counseling to 60 expectant fathers, found that "the husband's participation in counseling has almost uniformly facilitated

(Continued on page 36)

Kansas and The Children's Trust Fund

by Jean Glenn

In January 1981, *Children Today* carried a story about a unique piece of legislation passed by the State of Kansas. It established a Children's Trust Fund which would be used primarily, but not exclusively, for the prevention of child abuse. It was the first state in the nation to enact such a law.

The original idea was developed by Ray E. Helfer, M.D. A pioneer in the field of child abuse and neglect, Dr. Helfer was then vice president of the National Committee for Prevention of Child Abuse.

The word "prevention" is the cornerstone of his philosophy about how to deal with the problem of abused children.

"I'm not saying that after-the-fact programs aren't good," he said in a recent interview. "After all, Sister Kenney and her hot packs and braces did a great deal of good for polio victims. But, if Salk and Sabin weren't, at the same time, working on research to find a vaccine to *prevent* polio, we'd still be using hot packs and braces instead of immunization."

In 1978, Dr. Helfer's thoughts were never very far from the problem of how to provide "dedicated" money to be

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Jean Glenn is a writer-editor, Office of Public Affairs, OHDS.

used for prevention of child abuse. Part of the answer came when he was sailing his boat on a small lake and noticed fish-rearing ponds financed by fishing license money. A psychologist friend who was with him suggested that maybe they should try to tax marriage licenses or birth certificates to fund "child-rearing ponds." But it wasn't until he was driving on the Interstate highway between Indiana and Ohio that he finally put it all together.

Why, he wondered, if a road can be built, without break or change in dimensions between one state and another—with even the directional signs the same shape and color—couldn't a plan be devised that would give the same uniformity to the collection and use of funds to prevent child abuse? The answer, he became convinced, lay in action within state legislatures until the Children's Trust Fund could be created across the nation in a fashion similar to the Highway Trust Fund.

His next speech happened to be to the National Committee for Prevention of Child Abuse's state chapter in Kansas. He threw away his prepared text and presented his idea. The response was immediate. Members of the chapter began at once to work with Governor John Carlin and individual legislators.

Dr. Helfer went back to Michigan State University where he is a professor in the Department of Human Development, College of Human Medicine. He wrote a 34-page booklet in which he outlined a detailed suggested plan for making the Trust Fund a reality. The National Committee, through a grant from the McDonald's Corporation, published it and distributed it nationwide to all state chapters.

The results?

In January of 1980, Governor John Carlin made the establishment of a Children's Trust Fund part of his budget request. In early spring the Kansas Legislature passed the Bill, which established the first Children's Trust Fund in the United States. On April 16, 1980, it was signed into law.

This is how it works. A $7 surcharge is placed on every marriage license issued in the state. After statutory deductions, the money realized from the surcharge and earmarked for the Trust Fund comes to a monthly average of $10,500.

A second piece of legislation provided for a 14-member Children and Youth Advisory Committee. It consists of nine state agency members and five public members, appointed by the governor. The Committee advises the Kansas State Department of Social and Rehabilitation Services, which administers the Trust, on use of the funds.

The first year of operation, the Trust Fund received 52 project proposals and funded eight. Eligibility for funding was based on several factors: proposals had to be focused on primary prevention of child and/or spouse abuse; they had to be innovative and, if successful, have the potential for replication elsewhere; they had to fulfill a demonstrated need in the community; and they had to reflect community cooperation and support.

Special attention was given to geographical distribution of funds. Individual projects could not receive funding in excess of $15,000 unless the Advisory Committee judged a proposal to be exceptionally meritorious or regional in scope.

The following proposals were approved for funding as of January, 1981. All but one (Family Life Education) have been refunded for a second year. The projects and their locations in Kansas are:

- "Healthy Start," American Association of University Women, Atchison. This project establishes training and availability of volunteer visitors to offer support to new parents. Services are limited to parents of first-born children delivered at Atchison Hospital, upon written referral of the attending physician.
- "Family and Child Education Services," a coalition for prevention of child abuse organizations, Goodland. It establishes primary prevention services.
- "Self-Care Education Projects," Johnson County Coalition for Prevention of Child Abuse, Olathe. This is a self-care education course for elementary schoolchildren of working parents who do not have babysitters before and after school.
- "Family Life Education, On-the-Job," Kansas Research Institute, Lawrence. This is a primary child abuse prevention program, established through basic courses in family functioning skills workshops for company employees during working hours.
- Catholic Social Services, to establish a peer advocacy project for pregnant women and single parents, utilizing YWCA facilities, Topeka.

Three other projects were funded later:

- "Children in Crisis," Regional Crisis Center, Manhattan, to establish a child play support program for children who have experienced stress from family violence.
- "Ourselves and Our Family," a coalition for prevention of child abuse, Great Bend, to develop a broad program of primary prevention services.
- "Time Out For Parents in Wyandotte County," a county coalition for prevention of child abuse, Kansas City, to establish a respite child care program for parents.

When asked about the effectiveness of the Trust Fund, Governor Carlin said he remained committed to it because it provided services for children which assisted them to become self-sufficient and well-adjusted members of society.

"The Trust Fund makes it possible for communities to coordinate and utilize their own local resources and to design and administer their programs according to their own specific needs," he said. ■

Ed. note: As this issue goes to press the following states have passed, or are considering passage of, similar Trust Fund legislation: Washington, Virginia, Michigan, Florida, California and Alaska.

Understanding Mexican American Culture:

A Training Program

by Tonia Tash Lasater and Frank F. Montalvo

During the weekly meeting of the child welfare agency's parent education class, Mrs. Gonzales mentioned that her sons collected and sold aluminum cans. She explained that they used their money to buy school shoes. Last week, the boys made $3.50 and, Mrs. Gonzales said, "I told them, '$1.75 for you and $1.75 for me.'"

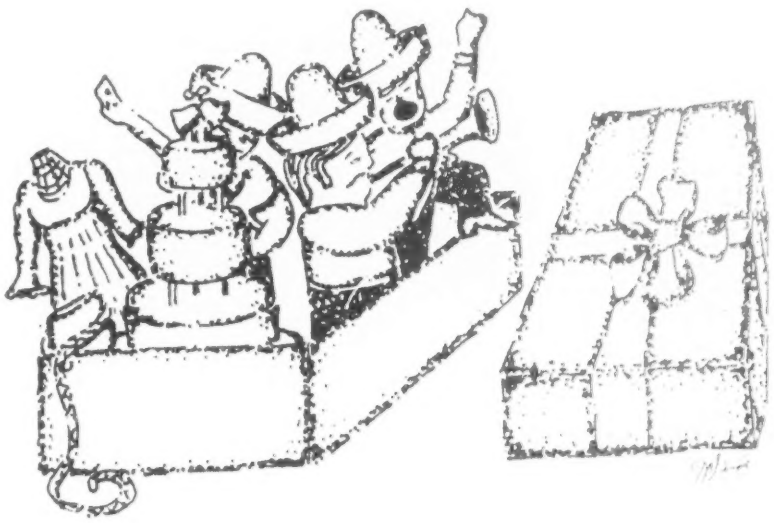
Mrs. Brown, the group leader, commented that Mrs. Gonzales might be expecting a little too much from the boys by asking them to give her half their money—and, she pointed out, since they were saving for school shoes, did it really matter anyway? Mrs. Gonzales did not respond to this comment. She didn't attend the next meeting—nor did Mrs. Garcia or Mrs. Nunez.

Why did these women drop out of the parent education group? While Mrs. Brown's comments did not appear to be out of place, they reflected *her* value orientation and not those of the Mexican American group members. When Mrs. Brown asked if splitting the money was really important, she did not recognize that Mrs. Gonzales was trying to teach her sons a basic cultural value. In the Mexican American community, children are taught at a young age that sharing, reciprocating and mutual aid strengthen family relationships and contribute to *familismo*, respect for and dedication to the family. In contrast, Mrs. Brown saw her client's actions as discouraging the children's independence and as possibly exploiting their achievement.

Another cultural value explains why the women did not make Mrs. Brown aware of their feelings, choosing instead to quietly withdraw from the group. Respecting an individual's feelings is important in the Mexican American community, as is the expression of deference. Deference is the consideration given to the opinions of others and out of respect, the women wanted to give the appearance of agreeing with Mrs. Brown.

Had Mrs. Brown been more aware of these cultural values, the women might have remained in the group. Mrs. Brown's lack of awareness, however, is not unusual among those who work with children and families from ethnic backgrounds different from their own. Nor is the high dropout rate of ethnic minorities an unusual occurrence in social service programs.

The need for developing responsive as well as equal services for ethnic groups was demonstrated in an extensive survey of mental health facilities by Stanley Sue, who found that 50 percent of minority clients drop out of treatment after one session, as compared to 30 percent of white, Anglo clients. He found that



Tonia Tash Lasater is director of the Child Welfare Curriculum Project and Frank F. Montalvo, D.S.W., is director of Continuing Education in Human Services and Culture Simulator Programs, Worden School of Social Service, Our Lady of the Lake University of San Antonio, San Antonio, Texas.

Children are taught that sharing and mutual aid strengthen family relationships and contribute to "familismo," respect for and dedication to the family.

"the persistent relationship between ethnicity and dropping out . . . indicates that ethnicity is an important correlate above and beyond the variables examined [such as social class, diagnosis, utilization rates and type of service rendered]. The explanation may reside in the experiences that clients have in face-to-face interaction. . . ."[1]

Teaching workers to understand cultural values and how they relate to service delivery has become an integral part of training designed to enhance social work practice. The large number of minority group clients within the social service system suggests a need for training materials to help practitioners meet the special needs of these clients.

One training tool, *The Mexican American Culture Simulator for Child Welfare*, was developed by the Worden School of Social Service, Our Lady of the Lake University of San Antonio, under a grant from the Children's Bureau, ACYF.[2] Designed to increase workers' understanding of and sensitivity to the culture, values and customs of Mexican American families, the instructional materials are adapted from the "Culture Assimilator" used by several multinational corporations to train business people and educators preparing to work abroad.[3]

The Mexican American Culture Simulator is a self-instructional module that contains descriptions of 40 incidents resulting from client-worker misunderstanding due to differences in their socio-cultural backgrounds. The intent is to improve caseworkers' empathic understanding of Mexican American children and families in a manner that encourages and supports their ethnic identity, integrity and community life. The simulator provides an introduction to the more traditional cultural values while allowing for variations in orientation and acculturation. It does not claim to teach a total awareness of the culture.

The focus on traditional values is justified on several counts. First, most child welfare clients live near, at or below poverty levels. Traditional customs and beliefs tend to be associated more with this group than with those in higher socioeconomic status who have experienced a greater degree of acculturation. Secondly, workers expressed more concern about misunderstanding those clients who were unacculturated to the majority culture than those who were more similar to themselves. Thirdly, certain core values are basic and shared by Mexican American families throughout the Southwest. Finally, since many of these basic, traditional values are shared by other Hispanic groups, much of the material could be applied in casework involving these groups as well.

The training approach is also cost-effective. The design and standardization of the materials enables trainers with varying backgrounds and expertise to use them with reduced risk of overgeneralizing and developing "new stereotypes," and to adapt them to various training periods, locations and needs. The case studies contain job-related information that directly relates to improving social work practice, and the exercises involve the trainee in an active problem-solving experience that is self-administered, self-paced and non-threatening.

Instructional Method

Each incident in the workbook is presented as a short vignette (about 150 words) depicting a problematic transaction between client and worker. The theme may relate to folk and/or religious customs and values, or deal with family roles and sense of pride.

The incident is followed by four multiple choice answers that provide alternative explanations for the client's or worker's behavior. Few of the answers are totally incorrect.

The trainee is asked to choose the best answer and to read the corresponding rationale, which explains why the answer selected is or is not the best one available. The worker continues selecting alternative answers and reading rationales until the best one is selected and confirmed by its corresponding rationale. It may require as few as one selection or as many as four before the reader progresses to the next vignette.

Rationales for the less-than-best alternative provide opportunities for correcting misconceptions, stereotypes or less appropriate intervention; rationales for the best answer explain the traditional value in the vignette and suggest more effective and culturally responsive intervention. The rationales are, therefore, the primary teaching devices.

The following example is taken from the trainee's workbook.

Cribs and Scissors

Mrs. Garza is working with the Navarro family, which has been referred to child welfare for neglect of their six children, ages 7 years to 3 months. On one of her visits she noticed a pair of scissors lying in the crib above the baby's head. Pointing out that the scissors were dangerous, she removed them. During a subsequent visit, Mrs. Garza finds the scissors protruding from under a pillow in the baby's crib.

This is how Mrs. Garza explained the client's needs in the case record.

A. Mrs. Navarro needs religious counseling.

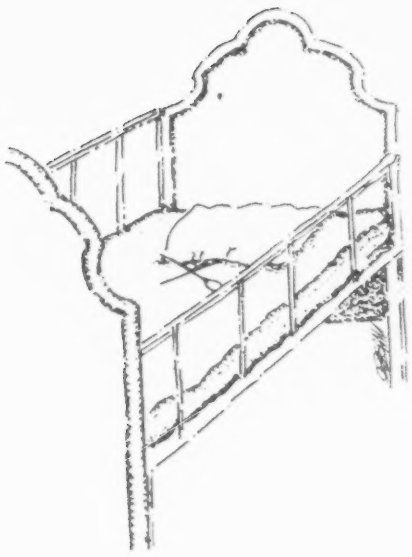
B. Mrs. Navarro needs child care classes.

C. Mrs. Navarro needs homemaker's services.

D. Mrs. Navarro needs psychological counseling.

The rationales corresponding to the vignette are explained as follows:

Rationale A (Religious Counseling). An Aztec folk custom from the areas near Mexico City and Texcoco involves placing needles in the form



Illustrations by Michelle Friesenhahn, from "The Mexican American Culture Simulator for Child Welfare."

of a cross over a door, window or under the pillow as a protective device to ward off something evil occurring. This is seen as necessary before a baby is baptized. However, there are more acceptable ways of carrying out this custom than by placing open scissors or sharp implements in the crib. They can be placed under the crib or a mirror hung at the head of the crib. Crossed palms—blessed—can be placed over the door. Or the baby can be baptized.

Rationale B (Child Care Classes). This is certainly not a good parenting practice. However, the indication is that parenting information alone will not correct the situation. Parenting classes may not be relevant to Mexican American culture in this respect. In changing parenting practices, as with any other behavior, it is wise to understand "where the client is coming from" before trying to reeducate her.

Rationale C (Homemaker Services). We do not have information in the vignette to support this choice. Also, while a homemaker in the home may change some of the problems this does not address the specific situation regarding the scissors. Certainly they are dangerous, but a homemaker is not necessary to convey this point. The caseworker can handle the potential danger involved.

Rationale D (Psychological Counseling). The assumption that there are psychological problems requiring counseling is premature, although it is often made when inexplicable situations are encountered. The caseworker needs to investigate the situation further and refrain from making judgments on the basis of one incident that he or she does not understand and has not examined with the client.

* * *

In this case, the first statement, A, is the correct response. What may first appear to be evidence of neglect or ineptness on the part of the mother is actually an expression of her concern for the well-being of the baby. While such an unsafe practice needs to be discouraged, an understanding of the cultural dynamics involved will suggest the appropriate intervention and solution of the problem. This is fully explained in Rationale A.

The other rationales contain explanations as to why the remaining alternative answers are less appropriate to the situation. They would be read by trainees who selected answers B, C and D.

Trainer's Manual

The training package consists of two volumes of vignettes and a trainer's manual.[4] The primary purpose of the trainer's manual is to assist them in helping workers clarify and integrate the knowledge gained as they progress through the exercises.

Background information and a detailed analysis are provided for each vignette. The analyses identify the focal value or custom in the incident, as well as other values, customs or stereotypes that may appear either in the incident itself or in the alternate answers. For the "Cribs and Scissors" vignette, for example, the trainer's manual provides the following information concerning the importance of religious practices and their relationship to folk beliefs:

"Baptism is an important sacrament not only because of its religious significance, but also because it serves to protect the child from misfortune. Folk customs, such as the one described in the incident, serve the same purpose, but are used as an interim measure until the child is protected by the church. The origin of these practices is Indian and their use in relation to Western religious practices is believed to be due to the scarcity of priests and churches in rural Mexico."

This brief discussion is followed by bibliographic references and a list of contrasting family values in the Anglo American and Mexican American communities.

The manual also contains suggestions to help the trainer relate the learning to trainees' everyday work experience. In the "Cribs and Scissors" analysis, trainers are reminded of the importance of remaining nonjudgmental, and of the fact that the culture may provide explanations for situations that they do not understand. Suggestions for obtaining accurate information and achieving treatment goals are also given.

All vignettes are cross-referenced according to value themes—sex-related roles, bilingualism and the role of grandparents and children, for example. For some themes, the trainer is provided with an analysis of the incident in order to help trainees identify subtle diagnostic clues in the vignettes that they can transfer to their own interviews with clients.

In addition, the trainer's manual includes instructions on the use of the module in training and suggests that following simulator training a period of casework practice follow the discussions in order to further increase its learning value and to test its usefulness in practice. In field-testing the module, however, significant results were obtained without the trainee's undergoing additional training.

Development of the Module

The materials were developed by project staff with the assistance of experienced child welfare workers from the Texas Department of Human Resources. Value themes were identified after conducting 30

(Continued on page 35)

NEWS & REPORTS

Healthy Mothers, Healthy Babies

National voluntary, professional and government organizations with a commitment to maternal and infant health have formed a coalition that aims to increase awareness among pregnant women of the importance of good health for themselves and their unborn babies.

The "Healthy Mothers, Healthy Babies" effort was sponsored initially by six organizations: American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American Nurses Association, March of Dimes, Parent Teachers Association and the U.S. Public Health Service. A conference to organize and form a steering committee was sponsored last fall by these groups and attended by representatives from some 30 others. Currently, more than 40 national organizations have joined the coalition, including the Child Welfare League of America, La Leche League International, the National Center for Clinical Infant Programs, Planned Parenthood Federation of America, the Salvation Army and the U.S. Department of Agriculture.

To exchange information among members, the American College of Obstetricians and Gynecologists publishes a quarterly newsletter. Among other activities, the coalition is preparing a directory of educational materials on prenatal and infant care for pregnant women and teenagers, parents and professionals, and is planning a teleconference to help promote breastfeeding to health care providers.

As part of the public awareness campaign, the Public Health Service and March of Dimes have produced radio spots, narrated by Surgeon General C. Everett Koop, giving advice on a variety of topics important to good health during pregnancy. The spots were delivered in April and May to radio stations by local March of Dimes affiliates.

Organizations that have a special interest in maternal and infant health, and that have a structure of state and/or local affiliates or other types of networks to reach members at regional, state or local levels, are invited to participate in the coalition. Application forms and additional information are available from Elaine Bratic, Office of Public Affairs, U.S. Public Health Service, DHHS, 200 Independence Ave., S.W., Rm. 740-G, Washington, D.C. 20201.

Free copies of the "Healthy Mothers, Healthy Babies" newsletter—or information on whom to contact for a newsletter in your national organization—may be obtained from the American College of Obstetricians and Gynecologists, Public Affairs Dept., 600 Maryland Ave., S.W., Washington, D.C. 20024.

Foster Care Rates

A set of tables indicating the average monthly reimbursement rates paid by each of the 50 states for foster family care has been developed by the Adoption Resource Center in Region VI. Preliminary analysis of the data shows the following average basic monthly payment rates:

- For children 6 years old and younger ____ $159.
- For children 6-12 years old ____ $192.
- For children 12 years and older ____ $246.

The lowest average monthly reimbursement rate—$123—is paid in Mississippi; the highest—over $400—is in Alaska.

All states also have provisions for monthly or yearly clothing allowances for the children.

Allowances for foster family care of children with special needs, such as those who are mentally, emotionally or physically handicapped, range from $131 to $900 a month.

Copies of the set of tables, which represent the most complete com-

pilation of rates by states currently available, may be obtained from the Region VI Adoption Resource Center, 2609 University Ave.—Suite 314, Austin, Tex. 78712.

Americans: Together Or Apart

Americans living together without being married have become recognized as a fact of life over the last 10 years. But the Census Bureau, based on a 1980 survey of about 65,000 households, not only documents this social change in a recent report but concludes that even more significant in the marital status of the population are the trends of postponement of first marrages, lifelong singleness and the rise in divorce.

Nearly half of the single men marry for the first time at the age of 24.6. This is more than a year later than 1970 figures indicated. Half of the women marry when they are just slightly over 21, instead of 20.8 as before. As more young people pursue higher education and job opportunities, they are choosing to live independently and to marry later—if at all.

Although the number of unmarried couples living together tripled during the time period of the survey, 23 percent of all households in 1980 consisted of one person living alone. Considered more surprising was the dramatically increased number of men and women in their late 20s who had never married. In 1970, one in every 10 women aged 25 to 29 had never married. By 1980, the proportion had doubled to one in five. For men in the same age range, the 1980 report showed that one in three had never married, a 70-percent increase over the one in five single in 1970.

While increasing proportions of the adult population are postponing marriage or never marrying at all, others who have married are ending those marriages in divorce at very high rates. In 1970, there were 47 divorced persons for every 1,000 married persons with spouse present. Within the last 10 years, the ratio rose 100 per 1,000. That means one in 10 were divorced and had not remarried. Also, divorced men remarry more quickly than their former spouses.

What happens to the children of broken marriages? The number of children who lived with only one parent rose by 4 million during the decade, or to one out of every five children in 1980. Ninety-two percent of the 12 million children in one-parent families lived with their mother. Boys made up a higher proportion of children who lived with both parents or with their fathers only.

The report had something to say about who is the head of the house, too. Prior to 1980, the husband was always considered to be the "householder." Now, 1.6 million married couples listed the wife as the householder. What's more, young wives aged 25 to 34 represented fully one-fourth of all wives who were recorded as "householders."

Single copies of the report, *Marital Status and Living Arrangements: March 1980*, Current Population Reports, Population Characteristics, Series P-20, No. 365, U.S. Department of Commerce, Bureau of the Census, are available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402 at $4.25 a copy.

Fitness For Children

PEP Up Your Life: Fitness For Children includes a 10-minute film, a leader's discussion guide and accompanying booklets explaining how parents and older brothers and sisters can engage children in physical fitness activities.

Produced by The Travelers Insurance Companies in cooperation with the President's Council on Physical Fitness and Sports, the film depicts easy-to-do activities that require little time and equipment. The illustrated booklet contains games and exercises for children aged 3-12.

The film, available for free loan, and booklets may be obtained from The Travelers Film Library, One Tower Square, Hartford, Conn. 06115.

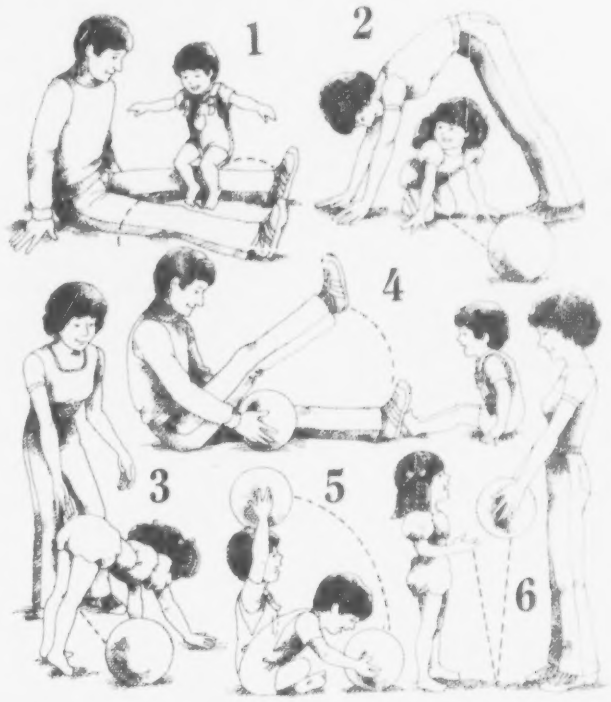


Photo: ALERTA Project

Dress-up time.

Photo: ALERTA Project

Developing communication skills.

Head Start Models Effective

A recent evaluation of four Head Start bilingual, bicultural curriculum models showed that Spanish-speaking children enrolled in them made significant gains over comparison groups in tests of English language acquisition, concept development and perceptual motor development. The children increased their English usage by 21 percent over the course of the year and they also showed significant gains in Spanish language production. There was no adverse impact on the learning of English-speaking children who attended the same programs.

These and other findings are contained in the executive summary of an ACYF report, *An Evaluation of the Head Start Bilingual Bicultural Curriculum Models*. The study was conducted for ACYF by Juarez and Associates, Los Angeles, in eight Head Start centers located in communities with comparatively large Hispanic populations.

The four Head Start curriculum models studied were developed in order to identify specific educational approaches for use with Hispanic children. (About 20 percent of children enrolled in Head Start are Hispanic.) As described by Soledad Arenas, director of the Head Start Strategy for Spanish-Speaking Children, in "Innovations in Bilingual/Multicultural Curriculum Development" (CHILDREN TODAY May-June 1980), the project was based on the assumption that children whose primary language is not English should be provided with preschool experiences in the language they know best. The goal was to develop curriculum approaches that would offer instruction in two languages, foster children's cognitive and social growth and allow for individualized instruction based upon a child's linguistic needs and differences. The four models are:

- The ALERTA Model, developed by Teachers College, Columbia University. It is based on two major principles or beliefs relating to a child's growth: that growth occurs as a child is impelled to engage in more and more complex ways of thinking, feeling and acting, and, secondly, that a child's total environment—home, family and community, as well as the classroom—plays a very important role.
- The AMANECER Project, developed by Intercultural Research Associates in San Antonio, which views learning as a continuous process, one in which past experiences help children gather information about themselves and other people, objects and events.
- The *Nuevas Fronteras De Aprendizaje* (New Frontiers in Learning) Project, developed by the University of California at Santa Cruz, which is based on the belief that a child's cultural background directly affects how he or she learns.
- *Un Marco Abierto* (An Open Framework) Project, developed by High/Scope Research Foundation. It is based on developmental theories of Piaget and views the young child as an active learner who increases his understanding of the world around him by exploring with all his senses.

All four models were involved in the evaluation study, which took place over a 3½-year period. Answers to three central questions were sought: What was the impact of the models on the children, their parents and their teachers? Was the curriculum successfully implemented at each of the evaluaton sites? And could the bilingual, bicultural curriculum models be successfully implemented in different settings?

All of the children studied for the evaluation—442 distributed across the eight evaluation sites—were

tested on selected standardized competency measures at the beginning of the Head Start year (Fall 1979) and at its conclusion (Spring 1980). In addition, a subsample of children at four evaluation sites were the subjects of intensive classroom observation during the year.

Mothers of the children involved in the experimental models and the classroom staff all expressed positive attitudes toward bilingual, bicultural education. As one mother said: "I want my daughter to speak both Spanish and English. This [bilingual] class is good because I know myself that I had problems going to college without a good knowledge of English and now my Spanish is not so good when I go back to Puerto Rico."

And the parent of an English-preferring youngster explained: "I want Eddie to learn Spanish and I would like to learn it myself because so many people in the community are Spanish speaking. I really enjoy it when Eddie comes home and tells me the Spanish words he's learned in class."

Among the findings for teachers in the model projects, the report notes that both they and teacher aides were positive in their opinion of the curriculum models. Many explained that the curricula supplied a structure and approach for providing learning experiences to children with different language preferences. The teachers also noted, however, that much planning and preparation was required to carry out all the suggested activities of each curriculum.

The social benefits of bilingual education for both Spanish- and English-preferring children were also stressed. "For non-Hispanic children," one teacher pointed out, "the child can understand his Hispanic peers and there is a greater degree of interaction. The cultural differences would be understood without prejudice." For Hispanic children, another teacher said, "They get a better self-concept because they recognize that speaking Spanish is just as good as speaking English. This helps them learn not to be ashamed of their language."

The evaluation study also points out that the curriculum models are adaptable to different geographical and cultural settings. The models functioned within a variety of administrative structures and they were successfully used in public school settings, church settings, independent Head Start centers and in half- and full-day sessions.

At present, the four Head Start Bilingual/Multicultural Resource Centers are providing technical assistance to approximately 160 Head Start programs throughout the country on the implementation of a model of their choice. The Resource Centers are also providing technical assistance in the adaptation of one or more of the models for Head Start Indian and Migrant programs and for Head Start programs in Puerto Rico.

Single copies of the executive summary, *An Evaluation of the Head Start Bilingual Bicultural Curriculum Models*, may be obtained by writing to Soledad Arenas, Head Start Bureau, P.O. Box 1182, Washington, D.C. 20201.

Choosing Children's Books

Parents, teachers, librarians and others seeking guidance on selecting books for children can consult two recent publications.

Children's Choices for 1981 is the 7th annual bibliography compiled under the direction of the Joint Committee of the International Reading Association (IRA) and the Children's Book Council. It offers an annotated listing of more than 125 books rated favorably by their intended readers—the children themselves.

Of approximately 3,000 children's books published in 1980, about 500 were preselected by IRA educators and sent to each of five teams for testing in classrooms, where the children voted on them. About 10,000 children had a chance to indicate their choices among the books, which cover a range of subjects for children in kindergarten through the 8th grade.

Single copies of *Children's Choices* may be obtained by sending a self-addressed envelope stamped with first-class postage (for 2 ounces) to Children's Choices, The Children's Book Council, 67 Irving Place, New York, N.Y. 10003.

Children's Books of the Year—1982 Annual Edition, prepared and published by the Child Study Children's Book Committee at Bank Street College, lists more than 500 book titles selected by the committee from children's books published in 1980.

Entries are categorized by age group—from the nursery years to age 13—and subject. Topical categories include growing up, biography, adventure, fantasy, folk tales and legends, science fiction and sports. Books considered to be of outstanding merit are noted, as are inexpensive books of high quality. Good new editions, which bring old favorites to the attention of new readers, are also included.

The annotated booklist can be obtained by sending $3.00 (including postage and handling) to the Book Committee, Bank Street College of Education, 610 West 112th Street, New York, N.Y. 10025.

Tooth Decay Declines

The prevalence of tooth decay among schoolchildren has decreased substantially over the past few years, according to a nationwide survey conducted by the National Caries Program, National Institute of Dental Research (NIDR).

Although no single reason for the decline is offered, NIDR officials believe it likely that more widespread use of fluorides—including community water fluoridation, school-based fluoride tablet and mouthrinse programs and the use of dental products containing fluoride—has had a significant effect.

The survey was conducted during the 1979-80 school year by Westat, Inc., Rockville, Md. among children aged 5-17—the age group with the highest incidence of dental caries. Survey results showed that by age 12, children have, on the average, more than four decayed, missing or filled-tooth surfaces in their permanent teeth. (By age 17,

they have more than 11.) Females were found to have a slightly higher incidence of caries than males in permanent teeth at every age, and children living in urban areas where fluoridated public water supplies are common have a lower prevalence of tooth decay.

Results of the survey, showing findings by age, sex, race, geographic region and other demographic variables, are presented in *The Prevalence of Dental Caries in United States Children 1979-1980*. Single copies of the 159-page report are available free from the National Caries Program, Westwood Bldg., Rm. 532, 5333 Westbard Ave., Bethesda, Md. 20205.

Making Friends

How friendships develop between children with handicaps and their non-handicapped classmates is the theme of *Making Friends*, a series of three 10-minute films and accompanying teacher's guides for use in grades 2-5.

The films depict three groups of children, ages eight through 12, meeting, becoming friends and resolving problems in order to maintain their friendships. As children view and discuss the films, they explore attitudes, values and individual differences and, through teacher-directed activities, learn basic skills to facilitate friendships.

Each film tells the story of friendships reenacted by real children, one of whom in each group has a disability. Each relationship has a unique beginning, and the children's friendships grow in different ways.

Robert, for example, actively reached out to befriend Fon Fon, a new boy in the class who wears braces and crutches. Robert sensed Fon Fon's loneliness but also responded to his energy and sense of humor. They are shown working through a test of their friendship when, in the third film, Robert is forced to choose during a game between Fon Fon and other children in the class.

Mia, however, at first avoided Jessica, who is in a wheelchair, paralyzed from the waist down. Gradually, the girls come to know and admire each other's abilities in music and bowling, and they become closer during these activities. The friendship isn't cemented, however, until, in the second film, they unite to confront a common enemy. (Jessica tells Mia to get behind her wheelchair and push her so they can "run down" another little girl who is terrorizing them.)

The films were developed by the Carkhuff Institute of Human Technology, Amherst, Mass., under a grant from the Office of Special Education, U.S. Department of Education, and produced by WGBH-TV, Boston. A version of *Making Friends* is available for broadcast by Public Broadcasting Stations (check local listings).

The *Making Friends* package for use in schools and other settings is distributed by The Production House, Inc., Pond St., Essex, Mass. 01929. The videocassette package (three 10-minute cassettes, a poster and teacher's discussion and skills guides) is available for $200; the film package (16mm films, poster and teacher's guides) is $355. Screening copies may also be ordered for $35 (applicable to purchase).

Chronically Ill Children

Coping with a child's chronic illness is the focus of two pamphlets for parents published by the Association for the Care of Children's Health under a grant from ACYF's Office for Families.

The Chronically Ill Child and Family in the Community (30 pp., 75 cents) is designed to help families deal with some concerns of daily living with a child or adolescent with a chronic health problem. "Try not to allow the sick child or the disease or disability to dominate all phases of family life," it advises, and it encourages parents to participate in support groups and advocacy organizations related to the health problem.

The pamphlet discusses such issues as helping other children in the family cope with their feelings, disciplining the ill child, taking a family vacation, maintaining positive relationships with the child's health care team, obtaining appropriate schooling and encouraging a child's friendships. Suggestions on managing the costs of health care are included, as are lists of organizations and publications for both parents and children.

Preparing Your Child for Repeated or Extended Hospitalizations (16 pp., 75 cents) offers suggestions to help both parents and children cope with hospitalization. It discusses the needs of children at different ages, noting situations that could be stressful and how they might be alleviated. The pamphlet also contains a section on readjusting after hospitalization, together with information on the Ronald McDonald Houses and books and pamphlets that may be helpful.

Both publications may be ordered from the Association for the Care of Children's Health, 3615 Wisconsin Ave., N.W., Washington, D.C. 20016.

Katharine Lenroot Dies

Katharine F. Lenroot, who served as the third Chief of the Children's Bureau from 1934 to 1951, died February 10 at the Colonial Manor Nursing Home in Milwaukee. She was 90 years old.

A graduate of the University of Wisconsin, Miss Lenroot first came to the Children's Bureau as a special investigator in 1915, three years after the Bureau's establishment by Congressional Act. Charged with investigating and reporting "upon all matters pertaining to the welfare of children and child life among all classes of our people," the new Bureau was placed in what was then the Department of Commerce and Labor. Special concern for "infant mortality, the birth rate, orphanage, juvenile courts, desertion, dangerous occupations, accidents and diseases of children, employment, legislation affecting children in the several States and Territories" was mandated under the Act.

A study of infant mortality, estimated to be about 125 per 1,000 live births in 1912, was the focus of the Bureau's first research effort. It showed that the greatest proportion of infant deaths resulted from conditions existing before birth—and that family conditions and income were strongly associated with an infant's health. For example, Bureau investigators who visited the homes of more than 25,000 babies found that in one of the cities studied, Baltimore, Maryland, one out of every 27 babies born in the most prosperous homes died, as compared to one out of every seven babies born in poorer Baltimore homes. The Bureau also found that breast-fed babies had a better chance for survival during the dangerous first year than bottle-fed babies.

Miss Lenroot was appointed to head the Children's Bureau by President Franklin D. Roosevelt and her tenure spanned years of The Depression, World War II and the postwar years.

During her first eight years as Chief, the Children's Bureau concentrated on planning and building three programs developed under the Social Security Act of 1935: the maternal and child health program, which authorized grants to the states for extending and improving health services for mothers and children; the program for crippled children, which authorized grants to states for diagnostic and treatment services for children with handicapping illnesses; and the child welfare services program, which provided for "establishing, extending, and strengthening, especially in predominantly rural areas," services for the protection and care of "homeless, dependent, and neglected children and children in danger of becoming delinquents." Provision of these services, Miss Lenroot wrote in an article published in *Childhood Education* in 1935, reflects "recognition . . . that security and opportunity for children are dependent not alone upon family income but also upon parental intelligence and understanding and community provision for the health and social services which individual families, under modern conditions, cannot provide singly."

Concurrent activities of the Bureau included administration of the child labor regulations of the Fair Labor Standards Act.

During the Second World War, the Bureau developed the largest public maternity program ever undertaken in the United States. This was the Emergency Maternal and Infant Care program for wives and infants of servicemen in the first four pay grades of the Armed Forces. Known as EMIC, the program was organized and administered by state health departments with federal funds. About 1,500,000 wives and infants had received care through EMIC by the time the program ended in 1949.

Writing to Miss Lenroot on the occasion of her retirement in 1951, President Harry S. Truman said: "The children of this country are better off for your having been in the government. What greater satisfaction could anyone take into retirement?"

BOOKS

Children Out Of Court

F.M. Martin, Sanford J. Fox and Kathleen Murray. Scottish Academic Press (distributed by Columbia University Press, New York), 1981, 331 pp., $27.00.

Reviewed by Jay Olson

A system for dealing with children who commit offenses or who for other reasons were deemed to be "in need of compulsory measures of care" went into effect in Scotland in 1971. A child "in need of compulsory measures of care" covers the categories of neglect, abuse and status offenses and the system is the subject of extensive research by the authors, who examined its operation throughout Scotland in the late 1970s.

At the heart of the system was the establishment of juvenile panels made up of laymen recruited in each local authority. Three panel members conduct hearings for children referred from a variety of sources. If the child and parents accept the "grounds of referral," the panel proceeds to consider what measures are called for. Should the grounds be denied, the matter is then brought before the sheriff (judge) having juvenile jurisdiction. In the event that the allegations which brought the matter before the sheriff can not be sustained, the case is dismissed. If the allegations are sustained, the sheriff will frequently refer the matter back to the panel for disposition. However, in the more serious cases requiring commitment or placement of children in out-of-home care, the sheriff will determine the appropriate care.

Serving each panel is a "report-

er" whose functions include screening and referrals. The reporter—whose background and experience are not prescribed by law—receives referrals from police, schools, agencies or individuals. He is free to decide whether or not to bring the child and parents before the panel, to arrange informal supervision by a social worker or to take no action at all. He also assists the panel on questions of procedure and performs administrative panel duties.

The juvenile panels have the power to make a variety of decisions and dispositions. Their alternatives include the following: assume supervisory jurisdiction over the child (either while he or she continues to live at home or is assigned to a residential school); admonish the child with or without a supervision order; require daily attendance at an attendance center; and a caution to the parents for their child's good behavior, a finding normally combined with a supervision order on the child. The panel may also decide that no further action is indicated.

It is important to note that a family may elect not to participate in the panel hearings and to have its case decided by the sheriff, thus preserving the right to their day in court.

The need for strong social work support in the work of the new panels led to the development of comprehensive local departments of social work, which took on responsibilities for the provision of supportive services to the panels.

Reform in the manner in which children's cases were to be handled was predicated on the following assumptions:

- The need to move away from the traditional punitive approach to the young offender, since delinquent conduct was often symptomatic of some maladjustment or failure to develop.
- A formally constituted judicial process was in itself likely to be harmful and potentially stigmatizing to a young person on the basis of inappropriate labeling.
- A children's hearing was seen as a forum in which all concerned—the child, parents, social worker and the panel members—would be able to talk freely about the problems that had led to the child's appearance.
- Heavy responsibility needed to be vested in social service departments, which would provide background reports and implement decisions made by the panels.

Criticism of the Children's Hearings has not been absent, particularly in the early years of the development and implementation. The hearings have been described as "toothless" and panel members identified as "do-gooders." The press reported that the hearings did little to control thuggery and hooliganism. However, the nature and extent of the criticism has never been the subject of a systematic study.

The Scottish system places particular emphasis upon a high degree of informality, using hearing rooms best characterized as simple and unpretentious. The simplicity of the setting is seen as a means of reducing tensions and encouraging full participation by the family. While some criticism has been directed towards the "casual" attitude to procedural requirements in some hearings, the authors feel that this problem is easily corrected by education and training of panel members and reporters.

In a concluding chapter of the book, the authors discuss significant changes in the American juvenile justice system during the last 13 years and the possible use of Children's Hearings in this country. The most significant change in the United States within the past few years has been the application of criminal jurisprudence to the juvenile justice process. The court as an administrator of child welfare services is waning while the administration of criminal justice for children is emerging. Evidence of this is reflected in the procedural safeguards and concern for due process by the appellate courts.

In addition, recent legislative changes in many states reveal that the traditional concept of providing for the best interests of children coming before the court is being replaced by statements identifying juvenile justice as a system of social control, one that is barely different from the criminal justice system.

While the emerging change is seen as an improvement over the traditional juvenile justice system because of the protections and procedural improvements now afforded youth, there is need for a less formal and non-adversarial approach for large numbers of youth outside the traditional justice system. A principal premise in this book is that society must exercise appropriate vehicles to control overacting to youthful crime, as the vast number of children and youth engage in unlawful behavior on a transient basis.

Time and maturation appear to be the most reliable means to ending delinquent behavior. The research by the authors indicates that the Children's Hearings afford room to both reform and protect growth in a humane environment while at the same time upholding the values of law.

Jay Olson is assistant to the director, National Center on Child Abuse and Neglect, Children's Bureau, ACYF.

Contemporary Parenting: Course Guidelines for Parent Education
Angelina B. Laycock, Patricia Ryan and Bruce L. Warren, Institute for the Study of Children and Families, Eastern Michigan University, Ypsilanti, Mich. 48197, 1981, 123 pp., $4.00.

Reviewed by Cecelia Sudia

This handbook for the instructor is very well done. The first several pages alert would-be teachers to pitfalls to avoid in establishing parenting courses for adults, most of whom don't care much for school.

The content areas (numbering 16 for a 20-meeting course) are each discussed in five parts: Goals, Ob-

jectives, Important Points (there are usually 25 to 30), Suggested Activities and Suggested Readings and Materials. The last section is divided into readings for parents and for instructors and includes a listing of available multimedia materials. Any of the suggested content areas could be dropped or used separately.

The most interesting aspect of this handbook is the range of issues covered in the 16 areas. These include such commonly discussed problems as discipline and problem behavior as well as aspects of special types of parent situations—the working mother, divorcing parents, single parents and stepparenthood. In addition, it has sections on less commonly discussed issues—adopted children, children with handicaps, children with compulsive eating habits and the problems of moving to a new home.

Since the proposed course content includes so much, it seems impolite to note some omitted issues: childrearing by parents who are widowed or unemployed. Also ignored are any special childrearing problems related to minority identity, although a carefully chosen instructor would cover this last issue and more attention could be paid to the others during the initial class discussions.

Cecelia Sudia is Family Services Specialist, Children's Bureau, ACYF.

Vulnerable but Invincible: A Longitudinal Study of Resilient Children and Youth
Emmy E. Werner and Ruth S. Smith, New York, McGraw-Hill, 1982, 229 pp., $18.95.

Reviewed by Edith H. Grotberg

Why do some vulnerable children seem to be invincible? The importance of examining environmental factors in children's lives that help them succeed, even when they show critical symptoms of being at risk, is well documented in this book.

So much of earlier research focused on identifying and remedying a problem, such as a handicapping condition, health impairment and abuse or neglect, that the roles of the immediate and community environment were not examined. Some researchers, including Virginia Shipman, Lois Murphy, Norman Garmezy, Bertrand White, the late Jean Carew and certainly the authors of this book, have been waging a quiet revolution in how we study children. They use a transactional model for study which means they examine the transactions between children and their families and the broader environment to determine what factors enhance or impede development.

In *Vulnerable but Invincible* the authors, Emmy E. Werner, professor of human development at the University of California, Davis, and Ruth S. Smith, a clinical psychologist in private practice on the island of Kauai, Hawaii, go beyond identifying the critical factors in promoting child development; they identify those factors which enhance child development when the evidence of risk is very great. In short, they set out to determine why some vulnerable children seem to be invincible.

The book analyzes data from a longitudinal study begun in 1955 on the children born on the island of Kauai. These children were examined (and their parents interviewed and their teachers consulted, as appropriate) at the ages of 2, 10 and 18 years to determine their developmental status. The phenomenon the researchers were particularly interested in to report on in this book was the ability of some of the children to become well-adjusted youngsters and resilient youth, even though they had experienced perinatal stress, ill health and/or economic and family disruption problems.

Comparing these invincible children with their counterparts who succumbed to the stresses of their own and their environmental conditions, the authors identified those factors which made for invincibility. These factors may be different at each age level. Thus, for infants, the critical factors were the eliciting and receiving of a great deal of attention during the first year of life, no prolonged separations from their primary caretaker during the critical time period for the development of attachment, and being perceived by their caretakers as very active and socially responsive infants. For children ages 2 and 10 the critical factors were related to household composition—more than one supportive adult available, the presence of sibling caretakers and the positive model of a working mother. The resilient children for these ages "appear to derive from life events and the available models in their household those attributes that complement each sex: autonomy and independence for the resilient girls; caring by nurturance for the resilient boys; competence for both."

For teenagers, the critical factors were parental attitudes of understanding and support, an ability to seek and utilize information in times of major psychosocial transitions, the constructive use of peer counselors, the receiving of advice and counsel from older siblings, cousins and other relatives and the holding of a strong religious faith.

Many nuances and complexities among the findings cannot be presented in this brief review; the book must be read to attain fuller understanding of these resilient children.

The book provides a great deal of information that can contribute to the development of more appropriate programs for children. Clearly the need for informal networks, the value of experiences with older and younger siblings, and the kinds of supportive behavior parents can engage in have implications for improving experiences to help children become more resilient.

Edith H. Grotberg, Ph.D., is special assistant to the Associate Commissioner for Developmental Services, Administration for Children, Youth and Families, OHDS.

Reprints of Note

McGuffey's Eclectic Readers: Primer through the Sixth Eclectic Reader, Revised Editions

New York, Van Nostrand Reinhold Co., available through the Smithsonian Catalogue (Item No. 1501), Smithsonian Institution, P.O. Box 2456, Washington, D.C. 20013, $27.50 for the set of seven books ($24.75 for members) plus $2.50 for shipping and handling.

Reviewed by Judith Reed

Reproduced here is the 7-volume set of those famous schoolbooks of another era: the McGuffey Readers. The open book in the photograph shows pages 6 and 7 of the first volume, the *Eclectic Primer, Revised Edition*, 1909. The introduction to the book, first copyrighted in 1881, notes that the method pursued in it is the same as that used in the Revised Readers—only about six new words are to be mastered in each lesson and the book's plan is such that a teacher "can pursue the Phonic Method, the Word Method, the Alphabet Method, or any combination of these."

The *Primer* begins with the alphabet, followed by Lesson I ("A cat and a rat") and continues through narrative, anecdote and poem to Lesson LII, a 3-stanza poem which ends: "All your joys and griefs he knows, / Sees each smile and tear; / When to him you tell your woes, / Know the Lord will hear."

Planned for "the first year of school work," the *Primer* is recommended for use before students receive their first reader. Also in the set is McGuffey's *First Eclectic Reader, Revised Edition*, 1920 (first copyrighted in 1879). It progresses from Lesson I ("The dog ran") to Lesson LXIII, the last in the book, which notes: "Your parents are very kind to send you to school. If you are good, and if you try to learn, your teacher will love you, and you will please your parents." It also exhorts readers to "Be kind to all" and, a bit ambiguously, cautions them not to "waste your time in school."

Many black and white pictures illustrate the slim, early volumes. The number of pictures diminish as the words and readers' skills increase: only eight illustrations appear in the 464 pages of the final book in the series, the *Sixth Eclectic Reader, Revised Edition*, 1921. Selections from 111 writers, nearly all of them American or English and only seven of them women, make up the reading text. (Aside from Elizabeth B. Browning and Helen Hunt Jackson, the female contributors are largely unknown here today: Felicia D. Hemans, Mary Russell Mitford, Adelaide Anne Procter, Hester Lynch Thrale and Adeline D.T. Whitney.) Other authors include Joseph Addison ("Discontentment: An Allegory"), Coleridge ("Ode to Mt. Blanc"), Dickens ("Death of Little Nell"), Patrick Henry (a selection from his 1775 speech before the Virginia Convention), Thomas Jefferson and Benjamin Franklin, Poe ("The Raven") and Shakespeare (nine selections).

For history buffs, for nostalgia buffs, and for all those interested in children's lives and the changing patterns in educational concepts and practice, the series offers fascinating browsing.

Workshops on Wheels *(Continued from page 10)*

- The provider is currently caring for state-funded children (previously considered Title XX children) or has signed a contract with the intention of caring for state-funded children.
- The home has at least three full-time children under six years of age at the time of the visit.
- The home is in a geographic area identified by demographic data as one that has a high concentration of low-income families with children under six.
- The caregiver intends to care for children for three or more years.
- The caregiver feels she needs the program's services and will benefit from them.
- The home or center is licensed by the state.

Day care providers most often learn of Seattle Day Nursery's program from their state licensors at an initial orientation. By manning display booths at conferences and by participating in workshops and professional meetings, specialists also spread word of the program. As the number of "graduates" has grown, word-of-mouth advertisement has increased as well. In addition to directly serving children and caregivers, the program has had an impact in other ways. After consulting with Seattle Day Nursery, several communities in the State of Washington have begun similar programs. Inquiries about it have come from communities in California, Hawaii, Oregon and Illinois, and presentations on the Mobile Resource Program have been featured at regional and local education conferences.

We believe that the Early Education Mobile Resource Program has widespread applicability and we encourage other communities to explore this versatile method of delivering training to day care workers. ■

Mexican American Culture *(Continued from page 25)*

group interviews with 180 key residents from low-income Mexican American communities in San Antonio.

Vignettes, based on the themes identified, were composed and tested at various stages of the project and in various teaching formats by 73 non-Mexican American workers in child welfare and family service agencies serving Mexican American families throughout the state. All test groups showed a significant increase in their knowledge of Mexican American culture and in cumulative learning.[5]

Construction of the module was based on the results of the evaluation. A similar array of themes was included in each of two volumes in order to minimize trainer's fatigue and to allow for a period of discussion and implementation into casework practice between the use of the two volumes, which contain a total of 40 vignettes. Neither volume is significantly more difficult than the other, although progressive order of difficulty was employed in each volume in order to maintain the reader's interest and to encourage his or her involvement.

Application

The Mexican American Culture Simulator for Child Welfare can be adapted to serve many training needs—as a component in competency-based curricula, for example, or integrated into community workshops, agency in-service training or university courses. It can be used in a variety of courses dealing with minority groups, human behavior and child welfare, and the vignettes can be used as a basis for group discussion and role playing.

Workers participating in cultural awareness workshops found the technique to be motivating, enjoyable and informative in learning to understand Mexican American culture. They pointed out that the materials were realistic—"I have a case just like this," several commented—and enabled them to integrate their knowledge. One worker said, for example, "I now understand what was happening in my case."

The workers also indicated that the workshops stimulated their interest in other cultural groups and helped them to recognize the influence of their own values on their social work practices.

Based on the success of the Mexican American Culture Simulator, project staff members are developing similar modules for use in other settings, and a Mexican American Culture Simulator for Mental Health is currently being developed by the Worden School of Social Service. ■

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[1]Stanley Sue, "Community Mental Health Services to Minority Groups: Some Optimism, Some Pessimism," *American Psychologist*, Aug. 1977.

[2]A resource manual to assist workers who provide services to clients from Raza (Hispanic) communities has also been prepared under a grant from the Children's Bureau. Entitled *Serving La Raza: Manual for the Human Services*, the manual was developed by Rodolfo Arevalo and Christine G. Martinez of the School of Social Work, San Jose State University, San Jose, Calif. It contains four modules designed to increase workers' sensitivity to children and families in Raza communities and to enhance their effectiveness in working with them. Additional information on the manual may be obtained from Rodolfo Arevalo, School of Social Work, San Jose State University, San Jose, Calif. 95192.

[3]Fred E. Fiedler, Terence R. Mitchell and Harry C. Triandis, "The Culture Assimulator: An Approach to Cross-Cultural Training," *Journal of Applied Psychology*, Vol. 55, 1971.

[4]Copies of the training package may be obtained for $27.50 each (plus $1.50 postage and handling) from Worden School of Social Service, Our Lady of the Lake University of San Antonio, 411 S.W. 24th St., San Antonio, TX 78285.

[5]See F.F. Montalvo, T.T. Lasater and N. Garza, "Mexican American Culture Simulator for Child Welfare: Technical Report," San Antonio, Our Lady of the Lake University, 1981 (ERIC Document Reproduction Service No. ED 207 736).

communication and closeness between husband and wife."[28] Sherefsky and Yarrow also reported that all women they counseled, regardless of method utilized, experienced better adaptation than non-counseled women, although a specific method called "anticipatory guidance" succeeded best.[29] Other researchers also suggest counseling, including exploration of feelings about pregnancy and parenthood for expectant parents. Such counseling would be an effective strategy for all expectant parents facing the anticipated stresses of pregnancy, as well as for those who may be undergoing crisis.

A third preventive strategy would be to train medical personnel and educators so that positive psychological processes could be facilitated through already existing relationships. Unfortunately, childbirth classes usually do not begin until the seventh month of pregnancy and medical personnel rarely have time for lengthy emotional supportive contacts. However, familiarity with the stress factors associated with poor postpartum adjustment, family instability and child abuse could facilitate the referral process to mental health or other social services designed to preserve the integrity of the family unit.

Finally, an expansion of services for new parents such as parent support groups or hotlines would be helpful for those parents under extreme stress immediately after the birth of their babies. Educational and counseling programs offered by existing child protective service units, mental health agencies, family counseling services or medical social work would be an innovative approach to the prevention of faulty parent bonding and attachment or child abuse, and it could also reduce risks to individual and family growth.

Providing parents with the most effective and loving parenting techniques available would not insure that they would be emotionally or psychologically capable of implementing them. Several implications, however, can be drawn regarding the content of preventive strategies that may prove more effective than education in regard to parenting skills. Present research, for example, suggests that preparation for parenthood should include discussion of the husband-wife relationship in order to deal effectively with the transition period of pregnancy and birth. Assistance in successfully confronting the specific developmental tasks of pregnancy for both expectant parents should also be a component of any preventive or intervention strategy during pregnancy. Also, for those parents who do experience pregnancy or early parenthood as a crisis event, crisis intervention techniques may be helpful. Further investigation and research to determine the usefulness of these suggestions should be pursued.

A review of the literature points directly to a need to consider that the experience of pregnancy will have implications for the future happiness and growth of the individual parents and the marital relationship, and for their emotional involvement with the infant. Often, individuals endure stress and emotional conflict hidden from professional view. During pregnancy, a couple may be involved with numerous medical, mental health and family life education services. Professionals can utilize this period of pregnancy to provide essential, efficient and effective preventive measures to enhance the quality of family life and infant care. ■

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[1] P.M. Sherefsky and L. J. Yarrow, *Psychological Aspects of a First Pregnancy and Early Postnatal Adaptation*, New York, Raven Press, 1973 and N. Uddenberg, "Reproductive Adaptation in Mothers and Daughters," *Acta Psychiatrica Scandanavia*, Supp. 254, 1974.

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[4] Cindy C. Williams, R. A. Williams, J. M. Griswald and T. H. Holmes, "Pregnancy and Life Change," *Journal of Psychosomatic Research*, 19, 1975.

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[24] P. M. Sherefsky and L. J. Yarrow, op.cit.

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[29] P. M. Sherefsky and L. J. Yarrow, op cit.

House Calls *(Continued from page 4)*

shall be stored in a designated place and securely locked at all times.

Perhaps one of the most critical provisions is that local regulations shall include a plan, under direction of the district physician, for enabling persons administering medicinal preparations to acquire adequate knowledge and skill to do so safely. What constitutes adequate knowledge and skill and who shall be directly responsible for providing this training is a source of concern to both the medical and educational communities. Some jurisdictions have developed joint agreements between schools and health departments which allow for ongoing communication and involvement of the two agencies. Health department personnel are becoming members of school teams that discuss the educational and medical problems of students and accept the responsibility for providing care to them.

In looking towards the future it appears that this shared responsibility is the central answer to an effective school health care delivery system. However, the recurring question of whether, in a particular situation, the schoolteacher has the necessary knowledge and skill to competently and, equally important, confidently meet the school health needs of the child will continue to arise. It will probably never be satisfactorily answered by the Courts; the answer requires cooperation not confrontation. Legislation, rules and regulations will help. But it seems that the answer to our school health dilemma will be found, as with so many other problems, in effective communication.

The educator must educate the physician. And the physician must take an active role in educating the educator. Surely patient education has been a vital part of medicine in the 1970s, but in the 1980s it must be expanded to the schoolhouse. Without mutual cooperation, communication and education, the answer to the question, "Doctor, do you make schoolhouse calls?", may very well have to be, "yes." ■

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[1] *Tatro v. State of Texas* (USDC, M.D. Tx.) was decided May 26, 1981 and an appeal is possible. A similar lawsuit on catheterization in schools occurred in Pennsylvania and it appears possible that the Supreme Court may review that case (See *Tokarcik v. Forest Hills School District*). As of this time, however, the cases on catheterization are controlling only for the states and districts involved. Case law which would have national application has yet to be set down.

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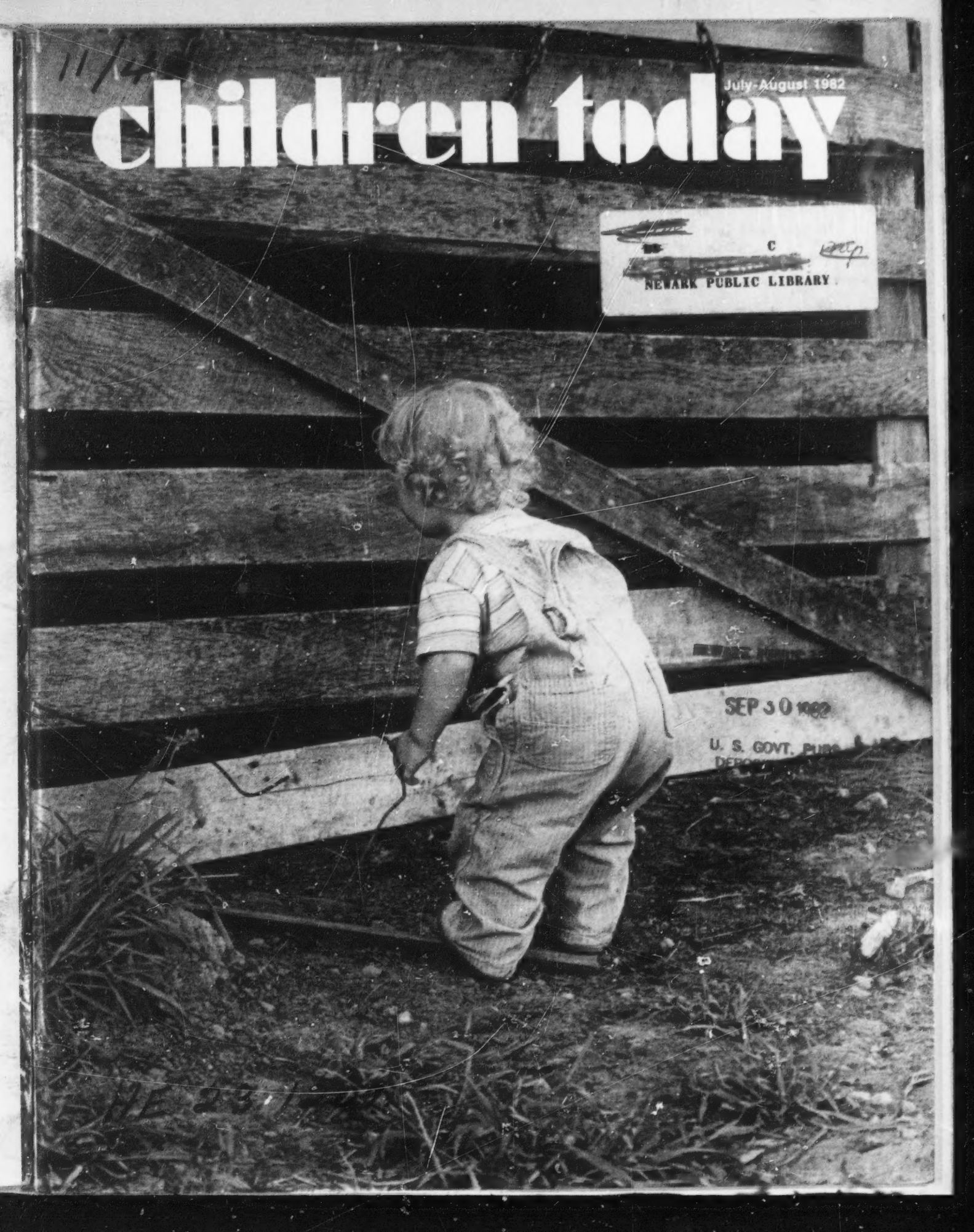
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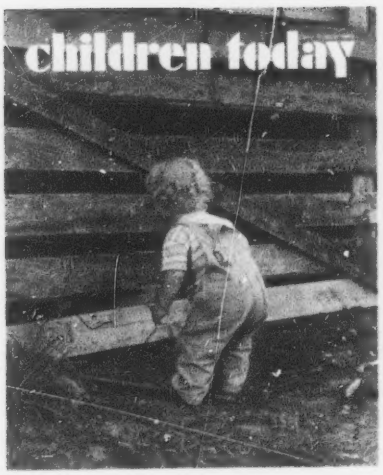

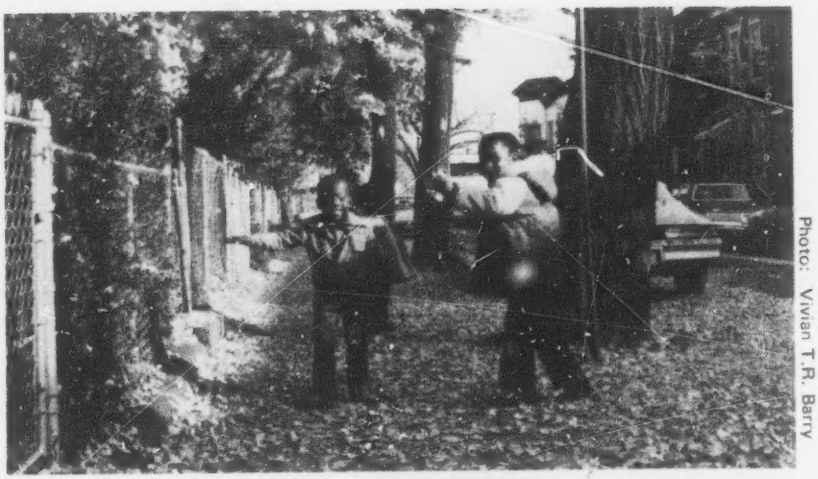

Photo: Vivian T.R. Barry

Photo: Post Wolcott, Library of Congress

Top: The autumn sport of kicking leaves, Washington, D.C. Above: Children playing in Defrees Alley, N.E., near the Capitol.

☐ Chances are that you will be hearing more about a simple scale that can be used as an analytic tool in planning permanency for children in foster care. The FLI (Foster Life Indicator) was developed by Wayne G. Spaulding, administrative coordinator of the Delaware Foster Care Review Board. In our lead article, he shows how it can bring "substance and concrete meaning to the phrase, a 'child's perception of time.'"

☐ More than three-quarters of civilian employer-sponsored day care centers were operated by hospitals, according to the most recent—1980—report on the subject from the Women's Bureau, Department of Labor. So when we heard that Mount Vernon Hospital in nearby Alexandria, Virginia had opened a new center for children of their employees last January, Carolyn Reece and Richard E. Swartz went to look, talk with parents and caregivers and observe and photograph the children and adults. The story and pictures they returned with begin on page 16.

☐ How urban neighborhoods enhance or hinder child and family life and how earlier living patterns continue in some areas and have changed in others are some of the questions Vivian T.R. Barry considered in a recent study and in the related, current exhibition she designed, "KIDSPACE: Using The City." Illustrations from the traveling exhibition are included on this page, as well as in her article, which starts on page 11.

☐ A service many parents will wish had been available to them is described by Carol Klein in her article on a pediatric counseling service which includes phone-in hours, private consultations and parent education group meetings, all under the aegis of the University of North Carolina's Child Development Institute in Chapel Hill. (See page 22.)

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The Foster Life Indicator:

A Tool for Planning

by Wayne G. Spaulding

A child's perception of time is considerably different from an adult's, particularly when the time is a period of separation from parents and siblings. The emotional attachment of a parent to a child may not suffer irreparable damage during the course of a 6- to 12-month separation but the same may not be true for a child. Older children may also endure the strains of a temporary separation from parents with lesser effects than young children.

The difference in how children and adults perceive time has been acknowledged and intuitively understood by many practitioners in the field of foster care and the need to incorporate this vital consideration into the foster care placement decision process has long been recognized.

In my search to find some way to include the child's perception of time in our planning process, I developed the Foster Life Indicator, a scale that we have been using as an analytic tool in the State of Delaware since June 1980.

The Foster Life Indicator (FLI) is a scale running from .00 to 1.00 which indicates the portion of a child's life spent in foster care. A child who has never been in care would have an FLI of .00; a child who has been in care half his life would have an FLI of .50; and a child placed at birth would have an FLI of 1.00. The FLI then is a simple computation obtained by dividing the number of months (or years) a child has spent in foster care by his or her age in months (or years). Since the scale expresses the term of a child's placement in relationship to his or her age, it can be used across the entire age spectrum of children in foster care.

Just as the age of a child is not static, neither is his or her FLI. Suppose a 3-year-old entered care today. His FLI would be .00. In six months, if he is still in care, it will be .14, in 12 months, .25 and in 18 months it will have risen to .33. At that time the child will be 4½ years old and he will have spent one third of his life in foster care. For a 3-year-old, 18 months is an extremely long period of time, particularly in terms of physical and emotional growth. If the same child stayed in care for the median 3-year term of placement, he would be six years old with a .50 FLI. An "average" placement of 5.5 years would yield an 8-year-old with an FLI of .65.

Initial Use of the FLI

The Foster Life Indicator was developed and first used to analyze the State of Delaware's foster child population. Identifying and descriptive information for each of the 939 children in foster care on June 1, 1980 was collected by the Delaware Foster Care Review Board, a 21-member volunteer citizen board established under Delaware's Foster Child Review Act of 1979. The data were collected to form a basis for monitoring the entire foster child population and to give the Board sufficient information for the selection of a representative sample of foster children.

Since there was no central registry of foster children in Delaware, a survey approach was adopted to collect specific information on the children. All social workers in child placement agencies were asked to fill out a form yielding the following information: the child's name, birthdate, race and sex; any special needs of the child; whether or not the child had siblings; whether or not the child's birth parents were still actively involved in planning for his or her future; what foster setting the child was in; the reason for entering care (abuse, neglect or dependency—the three statutorially defined terms in Delaware) and the date of the child's most recent entry into foster care.

Verification that all children in foster care had been identified was accomplished by comparing the information received with the state's payment records.

As with any measure, the FLI is used to clarify and yield an added dimension to an analysis and to allow plausible conclusions to be drawn. The accompanying Graph 1 represents the age distribution of the 939 children in foster care in Delaware. As can be seen, the bar for each year of age is divided into three parts. The striped top section of each bar represents all the children of that age who have an FLI of .67 or higher. These are the children who have spent more than *two-thirds* of their lives in foster care. The middle, white section of each bar represents children with an FLI of .34 to .66—children who have been in foster care for more than a third but not more than two thirds of their lives. The solid black section shows children with an FLI of .33 or less—those who have been in foster care for up to one-third of their lives.

The data in Graph 1 reflect the national description of an older foster child population. Among the adolescents, the white and striped portions of the bars represent many children who have been in care for considerable lengths of time. For example, a 15-year-old represented in the white

Wayne G. Spaulding is administrative coordinator, State of Delaware Foster Care Review Board, Wilmington.

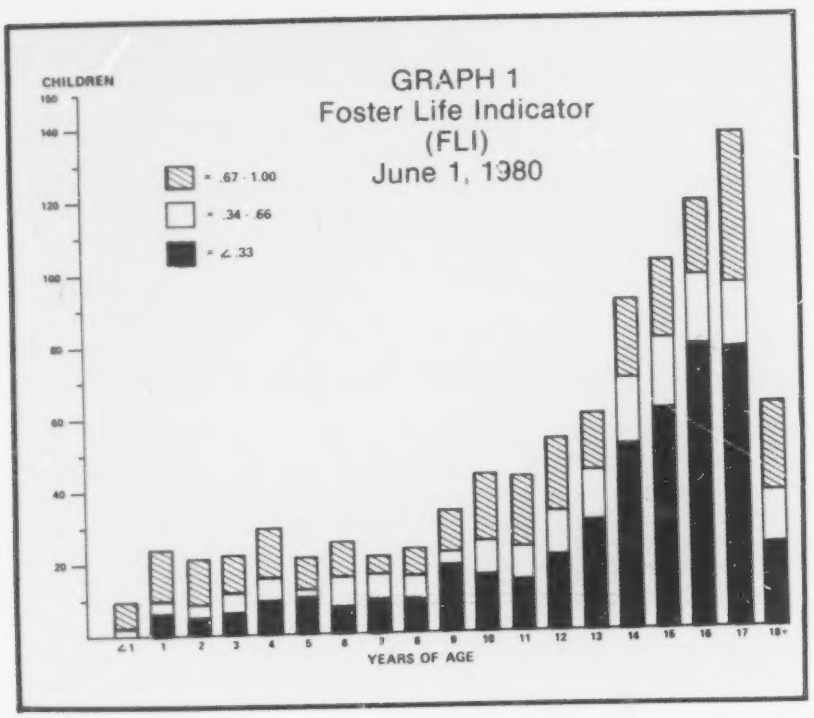
portion of the bar would have been in care for a minimum of five years and a 17-year-old, for a minimum of five and a half years. These are the minimum lengths of time in care for children of this age who appear on the graph above the black section. They represent long-term placements, as do also a portion of the children represented by the black section of the bars. Some of the children have been in care for over two years, while many others are recent entries.

Among the younger children, it would appear that the sands of time run faster. A placement of three to six months is a longer period of time, in terms of a child's age, for them than for older children. In that sense, the time does pass swiftly—a placement becomes a large portion of a child's life more quickly when a child is young. It's all a matter of proportion.

The accompanying Table 1 uses increments of .10 in the Foster Life Indicator to yield a more precise breakdown of the foster child population. It reveals that 28.5 percent of the children in care have an FLI of .10 or less; 14 percent have an FLI of .91 or greater; 38.2 percent have an FLI of .20 or lower; and 23.4 percent have an FLI greater than .80. In short, children with an FLI greater than .50 make up 42.4 percent of the foster care population. That means that at least four out of every 10 children in foster care in Delaware have been in care over half their lives.

TABLE 1
Distribution of Delaware's Foster Children By FLI

FLI Less than	Number of Children	% of Total	Aggregate % of Total
.10	268	28.5	28.5
.20	91	9.7	38.2
.30	75	8.0	46.2
.40	53	5.6	51.8
50	54	5.8	57.6
.60	55	5.9	63.5
.70	70	7.5	71.0
.80	53	5.6	76.6
.90	88	9.4	86.0
1.00	132	14.0	100.00



FLI Caseload and Cost Projections

The FLI may have value as a tool for projecting the future long-term foster child population. Focusing once again on the 17-year-olds reveals how such projecting is done. All the children represented by the striped area of the bar in Graph 1 entered foster care, at a minimum, by the age of six. By the time these children were nine, they had FLIs of .33.

There is no way of knowing how many 9-year-olds with FLIs of .33 (or greater) were in care on June 1, 1972 but there had to be at least 42 because that's how many 17-year-olds with FLIs of .66 (or greater) there were on June 1, 1980. A 17-year-old could only have an FLI of .66 (or greater) if he was in care at age nine with an FLI greater than .32. Put another way, today's 17-year-olds with FLIs of .66 were yesterday's 9-year-olds with FLIs of .33.

This leads to the possibility that the 9-year-olds with FLIs of .33 (or greater) may be tomorrow's 17-year-olds with FLIs of .66 (or greater). If so, these children will then be in foster care for eight more years—or a total of 135 child years for all these 9-year-olds. Assuming an annual cost for care of $2,500 per child, the total cost to the state for these additional years of foster care would be $337,500. That's just the cost for the 9-year-olds with FLIs higher than .33. Table 2 shows that there are 382 children in Delaware with FLIs greater than .32 and who have spent a minimum of three years in foster care. If they all remain in care until the exit age of 18, together they will log 2,096 years in foster care, at a cost of $5.24 million, an amount equal to the total allotment to Delaware for one year of block grant social service funding! And it should be noted that

this estimated cost reflects only the payment paid foster parents for the children's board; it does not include administrative costs, medical expenses, or special placement expenditures.

FLI and Children With Special Needs

The growing population of children in foster care is gradually becoming dominated by children plagued with a variety of problems. These children suffer from social deprivation, emotional/mental health problems, medical needs, abusive/neglectful parents, learning disabilities and substance abuse. Their special needs represent major barriers which must be overcome if permanent homes are to be found for them.

In Delaware, 42 percent of the children in foster care have been identified by their social workers as having special needs. Their problems run the gamut from multiple physical handicaps to drug abuse, from emotional disturbances to functional illiteracy.

Table 3 compares the average age, time in care and FLI of children with special needs with those factors for other children in foster care. In general, the children with special needs tend to be older and to experience shorter placements, as shown by their lower FLIs. Perhaps the families of these children cope with the child's problems as long as they can before seeking placement. Graph 2 illustrates this point by revealing the large number of children with special needs who are adolescent and who have FLIs below .11.

The gradual regression in health of children with certain medical conditions may partially explain the lower FLIs of special needs children. The regressive nature of a condition might force parents to eventually seek placement for an older child, once they are no longer able to provide the level of care needed. Children with behavioral problems may also contribute to the low FLI of children with special needs. And, finally, special needs children may enter and exit from care as their conditions fluctuate.

It should be noted that any previous placement experiences are not accounted for in this data. The FLI, as developed for the Delaware survey, did not include information on children's previous foster placements because our resources at the time did not allow for extensive data-gathering. As we undertake more extensive reviews of children's placement, we will incorporate previous placement data in calculating their FLIs.

Because previous placement experiences are not included in the

TABLE 2
Children In Foster Care A Minimum Of Three Years And With An FLI Of .33 Or Higher

Current Age	# of Children	Possible Remaining Years	Possible Child Years	$2500 per child year = 's
3	3	15	45	112,500
4	13	14	182	455,000
5	10	13	130	325,000
6	13	12	156	390,000
7	12	11	132	330,000
8	13	10	130	325,000
9	15	9	135	337,500
10	25	8	200	500,000
11	29	7	203	507,500
12	32	6	192	480,000
13	30	5	150	375,000
14	41	4	164	410,000
15	45	3	135	337,500
16	41	2	82	205,000
17	60	1	60	150,000
	382		2,096	$5,240,000

TABLE 3
Comparison Of Children With And Without Special Needs

	No Special Needs	Special Needs	All Children
Average Age	12.6 yrs.	13.1 yrs.	12.8 yrs.
Time in Foster Care	6.0 yrs.	4.8 yrs.	5.5 yrs.
FLI	.48	.37	.43

TABLE 4
Parents Present

	One Parent Present	Two Parents Present	No Parent(s) Present
No. of foster children	208	350	381
% of Total	22.1	37.3	40.6

FLI computation for the children discussed in this article, the FLI for some of them is understated, since they may also have spent an earlier period of time in out-of-home care.

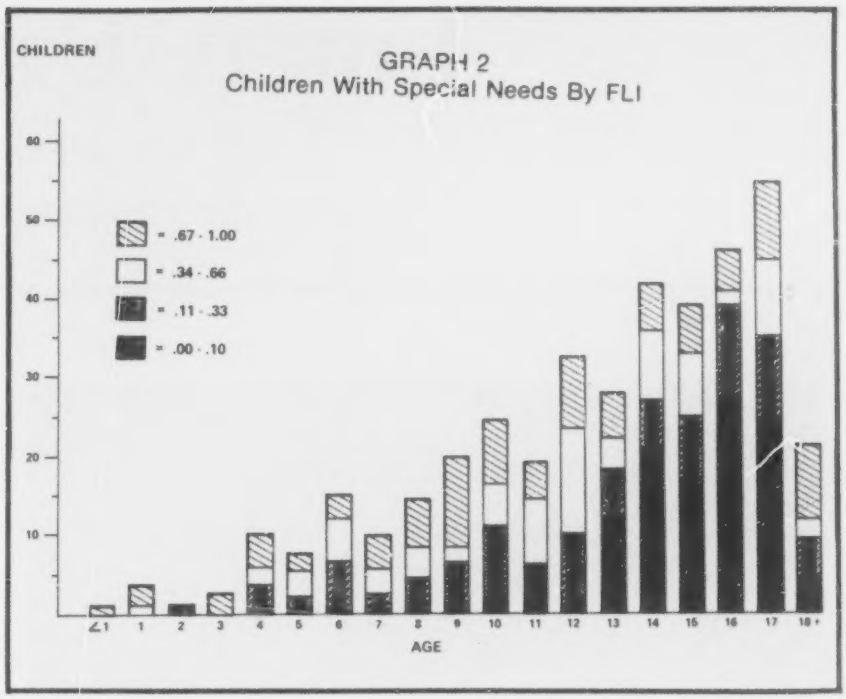
FLI and Parental Involvement

Achievement of the primary placement goal, the return of a child to his or her family, can only occur if the child's family works with the placement agency and the agency works with the family. The parents of a child placed in foster care must be available and willing to participate in the development and execution of a plan that will culminate in the child's return home.

More children than ever are being raised in single parent families. The additional pressures created by this family structure may result in the need for more foster placement. The successful return of a child to a one-parent home will depend upon the single parent being available and involved when the plans for the child's return home are developed and executed. When no parents are available or present, there is little likelihood that a child will return home. For example, Table 4 shows that 208 of the children in foster care (22.1 percent) currently have only one parent present; 350 children (37.3 percent) have two parents present; and 381 children (40.6 percent), have no parents actively involved with the placement agency in planning for their future.

Failure to return a child to his or her family within 18 months of placement increases the likelihood that he or she will never return. This 18-month barrier is well documented by research and has found its way into many states' service manuals and review legislation. But the one factor of placement which this time line does not take into account is the child's perception of time. Eighteen months—an adult time line—is a very long period for a child.

Relatively few children enter foster care because they have no parents present, that is, because they are orphaned or abandoned. In most cases, at least one parent is present and involved at the time of placement. The Delaware data showed that for children in care six months or less, only 10.6 percent had no parents present. For children in care for up to 18 months, a much larger percentage—19.7 percent—had no parents present. A variety of factors could account for this increase, not the least of which could be parental frustration with the process involved in return of the child. Of the children in care for more than 18 months (two-thirds of the state's foster children), more than half—51.4 percent—had no parents present.



What these numbers suggest is that parental participation in foster care or agency efforts to return children home decreases over time, reaching the critical point at about 18 months. If this is so, 18 months represents an average adult parent's perception of a reasonable term of foster placement.

In summary, it seems clear that a short-term placement, in terms of a child's perception of time, is a remote possibility when his or her parents are uninvolved. Conversely, the likelihood of a short-term placement is increased when parents are actively present.

Conclusions

By presenting the duration of a foster placement as a function of a child's age, the Foster Life Indicator makes it possible to conceptualize a child's perception of time. The FLI can be used alone or in combination with other variables to analyze and evaluate the entire population of children in foster care, or a segment of that population. It may also be used by the states or Federal Government to forecast future trends in foster care placements.

The examples cited in this article do not cover all possible uses of the FLI. In Delaware, the FLI was also used to analyze the racial and sexual composition of the foster care population, for example. Additionally, the FLI Delaware data was broken down by localities for cross-jurisdictional analysis and comparison. The potential value of the FLI to program planners, evaluators and budget officers has been demonstrated. Currently, concepts are being developed to apply it to individual case management, caseload management and judicial placement decisions regarding entry into care and subsequent case review. The FLI may be the long-awaited tool that brings substance and concrete meaning to the phrase "child's perception of time." ■

Lungs Unlimited:

A Self-Care Program for Asthmatic Children and Their Families

by Martha Pituch and Janet Bruggeman

Children draw their version of the respiratory system on a grocery bag—and display their artwork.

An estimated five to 15 percent of the children under 15 years of age in the United States are affected by asthma. Each year 20 to 25 percent of school absences (or eight million lost school days) are a result of asthma.[1]

Asthma is described as a bronchial disorder characterized by intermittent, variable and reversible airway obstruction.[2] Asthma episodes may be precipitated by a wide range of factors and are manifested through several symptoms. The episodes may vary in severity and may follow respiratory infection, exercise, changes in temperature and humidity or they may follow exposure to environmental irritants, such as pollen, smoke or chemicals. The clinical symptoms include difficult or labored breathing, coughing and wheezing with sputum production, and varying amounts of pulmonary insufficiency. In the past, asthma had been identified as a psychosomatic disease. However, with recent knowledge, this view is totally unsupported.[3]

As a chronic disease, asthma can have a profound effect on families. For example, D.S. Reddihough et al. reported that 57 percent of the families they studied reported that the disorder placed a great financial strain on all family members.[4] Other problems identified included anxiety, guilt (often due to a

Martha Pituch, R.N., Ph.D., is associate professor of nursing, School of Nursing, Medical College of Ohio, Toledo. Janet Bruggeman is program director, American Lung Association of Northwestern Ohio, Toledo.

familial background of hypersensitivity), overprotection of the asthmatic child, neglect of siblings, fatigue, irritability, overanxiousness and marital problems. Parents frequently expressed fears and anxieties about death and permanent damage to the heart and lungs of their asthmatic children. The researchers also found that half of the parents felt that their personal knowledge about asthma and its treatment was inadequate. Children perceived a lack of communication between doctors and their patients. However, the extent to which families understand asthma and its therapy has not been clearly documented.

In light of the needs and problems identified among asthmatic children and their families, the American Lung Association of Northwestern Ohio developed LUNGS UNLIMITED, an educational program based on self-care for asthmatic children and their families in a 6-county area in northwest Ohio.

LUNGS UNLIMITED provides education and counseling and teaches self-management procedures to children and families. Through proper breathing and relaxation techniques, and through such activities as karate and swimming, children work toward improving their ability to handle the disease. The self-management component also assists a child in building self-confidence.

The program emphasizes that the family unit is the primary force in coping with asthma. Parents and children are encouraged to practice breathing and relaxation techniques together, to express their feelings about asthma to each other and to use their new-found knowledge as tools to work together to reduce the number of problems previously associated with having an asthmatic child in the family.

In the program, separate sessions for children and parents are held concurrently. By interacting with the other children in their group, children see that asthma affects many others as well, and the group format gives them an opportunity to share the insights and understanding gained through their personal experiences.

Brothers and sisters of children with asthma may also enroll in the children's sessions.

Parents participating in LUNGS UNLIMITED find that a better understanding of the disease helps to relax the tensions that have built up as a result of the day-to-day dealings with their asthmatic child. In addition, sharing common experiences and voicing similar concerns with other families often diminishes parents' fears. Instruction in self-management techniques also helps parents learn how to deal more effectively with asthmatic episodes and to encourage their child to assume responsibility in managing the disease.

Through effective use of self-management skills, families attending may learn to successfully reduce the need for medical care and to lower the rate of their child's school absenteeism due to asthma.

Program Planning

To assess the need and interest for such a program, a half-day workshop for parents of asthmatic children was conducted at a local university. Of the 154 parents who attended, 97 percent indicated that there was a need for an in-depth educational program on asthma that involved both parents and children. A pilot program was then developed by the health educator from the American Lung Association of Northwestern Ohio, with input from the Pediatric Subcommittee of the Medical Advisory Committee.

Physicians, nurses, recreation specialists and respiratory and physical therapists from local communities were recruited to help contact families touched by asthma and to participate in conducting the sessions. To further highlight the community focus, local industries—Andersons (a grain industry) and Owens-Illinois—have provided funding for the program.

Five 2-hour sessions, held once a week, were developed for children, aged seven to 12, and their parents. The program is limited to 20 families per session and at least one parent of each child enrolled in the program is required to attend. Although parents meet separately, they cover the same six topics the children do: understanding the respiratory system; clinical aspects of asthma; management of the disease; psychological and psychosocial aspects; breathing and relaxation techniques; and self-management techniques.

Children's Sessions

The sessions for children, conducted in an informal, relaxed setting, begin with a 15-minute period in which general body exercises

emphasizing proper breathing are taught. These exercises serve not only to strengthen body tone and improve posture but also to provide a warm-up to the 45-minute activity period that follows. Depending on the facilities available, either swimming or karate instruction is given. Since swimming contributes to strengthening all muscles, especially the diaphgram and auxiliary respiratory muscles, it is an excellent exercise for children with asthma. Karate is especially useful in emphasizing breath control, self-discipline and body awareness.

Self-care, leading to self-reliance and responsibility, is a major thrust of LUNGS UNLIMITED. Both cognitive and affective learning help children to realize that they can minimize and sometimes even prevent asthmatic episodes. By applying that knowledge, they can assist the body in caring for itself.

In the first session, children are introduced to diaphragmatic breathing, concepts of tension and relaxation and the importance of fluid intake and exercise for individuals with asthma. A pre-test is administered to ascertain their knowledge of anatomy and physiology of the respiratory system, effects of medication and management techniques and myths related to asthma.

An icebreaker game is played to promote socialization and understanding of both tension and relaxation. Each child writes his or her name on a balloon, inflates it and releases the balloon to fly around the room. Guided by instructors, children pretend they are balloons by deeply inflating their lungs (feeling the tension in their bodies). Then, exhaling slowly, they move about the room. As their lungs empty, the children, following the instructors' example, collapse to the floor, limp and relaxed as the balloon. Each child picks up the closest balloon and walks around the room, meeting other children in an attempt to find the balloon's owner. The children and instructors discuss and demonstrate the difference between tension and relaxation and their effects upon the body while, at the same time, they establish social contacts.

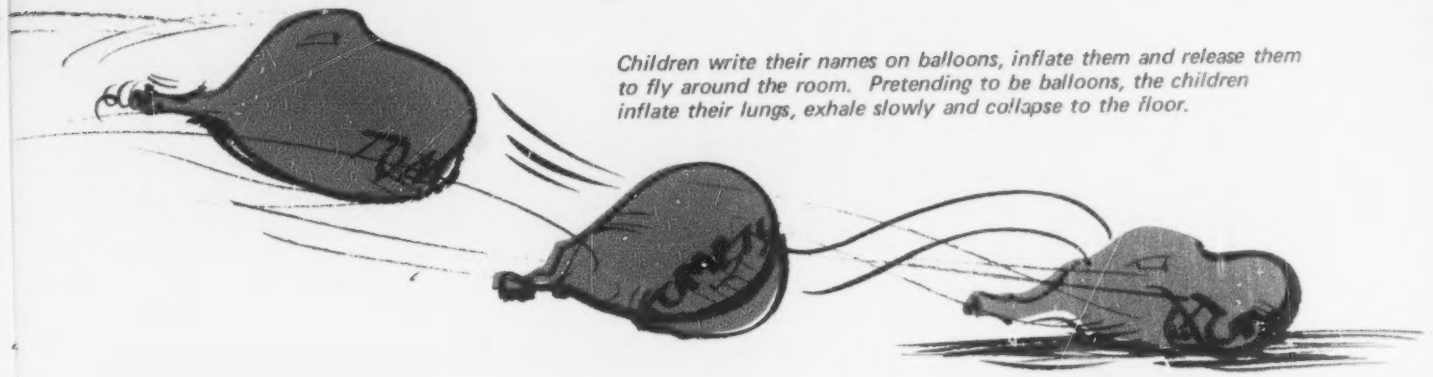
One of the primary self-care objectives of LUNGS UNLIMITED is to teach asthmatic children to skillfully utilize diaphragmatic breathing. During an asthmatic episode, children tend to breathe rapidly and shallowly as excess residual air remains in the lungs, limiting adequate air exchange and decreasing the vital capacity. This reaction may be counteracted by the use of diaphragmatic breathing, which helps to expel the increased residual air. The breathing technique is demonstrated in standing, sitting and supine positions. Children are instructed to practice diaphragmatic breathing often in the various positions during the coming week. Children also learn breathing exercises through the use of a relay game in which they blow navy beans across a table, in bubble gum contests, and by blowing on pinwheels constructed from paper plates.

The importance of drinking fluids, not only during a wheezing episode but also for general health maintenance, is stressed. The amount of liquids advisable varies according to the age and size of the child. (Guidelines for daily maintenance of fluids are 1¾ quarts of fluids per day for children aged five to 10 and two to three quarts for children aged 10 and over). Fluids are important in thinning excess mucus inside the airways and for replacing water lost during acute attacks in urine, sweat and water vapor. Children are cautioned to avoid cold liquids which may induce wheezing through a reflex spasm.

At the end of the first session, a brief review of self-care measures is provided, and the children are reminded to practice diaphragmatic breathing and to increase fluid intake, especially when an asthma episode begins. They also learn of the importance of this regimen in controlling a potential asthma episode.

Session two emphasizes progressive relaxation, a procedure that teaches children to consciously relax their bodies. Children lie on their backs (on top of non-allergenic blankets, towels or mats) while an instructor reads aloud the instructions. The children practice the process, and the instructor encourages them to set aside a short time every day to practice. An instruction sheet is given to each child to take home.

To teach children about the structure and function of the respiratory system, instructors wear T-shirts with a diagram of the system. As they explain each structure, they position a felt cut-out on a child's T-shirt. Pigs lungs are used to illustrate what the body parts look and feel like, as well as to demonstrate how the lungs expand and contract. To demonstrate what they have learned, the children draw and label their version



Children write their names on balloons, inflate them and release them to fly around the room. Pretending to be balloons, the children inflate their lungs, exhale slowly and collapse to the floor.

of the respiratory system on a grocery bag. Holes for heads and arms are made to allow the children to model their artwork. A prize is awarded to the child whose artwork is voted "Best of Show."

The third session begins with a general discussion of the defense mechanisms of the respiratory system (mucus, cilia, coughing and sneezing). The American Lung Association booklet, *As You Live—You Breathe*, is used as a teaching aid. The three anatomical changes that occur with asthma—bronchospasm, edema and increased mucus production—are outlined, and bronchoconstriction and production of the wheezing sound is illustrated by having the children blow through pinched straws.

In order to practice self-care, children must recognize when the body is functioning normally and when it is not. They must be able to differentiate between normal breath sounds and those of wheezing, which are characterized by whistling and audible breath sounds. Instructors teach children a simple way to identify breath sounds by placing a finger in each ear to block external sounds. Children are encouraged to practice this when they are experiencing no difficulty in order to identify what normal breath sounds are like and to test the procedure when they are having difficulty and are wheezing. Children also use stethoscopes to listen to normal or wheezing sounds in each other.

A brief introduction to asthma medications is also given, together with reasons for their use. Each child receives a handout, *Making Decisions to Take Medicine*, to complete and return at the next session.

In session four, discussions center around the types of medications used for asthma and the importance of good health habits. The various medications, how they assist the body to relax airways and loosen mucus and therapies used in the treatment of asthma are explained. Using the previous week's handout as a guide, each child's medication is discussed. Children are encouraged to share with others the names of their medications, how often they take them, their effect on the body and how to prevent side effects.

Group members also discuss general habits for good health. Most children are familiar with ways to keep healthy—exercise, proper nutrition, good hygiene and adequate rest—and the discussion allows them to share their knowledge. The discussion also serves to reinforce the importance of good health in an overall program of self-care to control asthma. Children also share the kinds of play activities and exercises they enjoy, and how they may handle an asthma episode if it should occur during play or exercise.

A discussion of smoking and its effects is included here and the children are helped to see how smoking may adversely influence their disease. Through a short course in assertiveness training, they learn how they may deal with persons smoking in their presence.

To stimulate a discussion about the psychological and psychosocial aspects of asthma, the topic of the final session, children draw a picture depicting their feelings about having asthma or living with someone who has asthma. The children describe their picture to the other group members and comment on each other's drawings. The purposes of the discussion are to help the children become aware of their feelings; to assure them it is acceptable to have these feelings and to express them; to encourage the concept of a healthy, positive self-image; to allow them to vent their frustrations; and to point out how having asthma can be "used" and why this can be detrimental to their physical and mental well-being.

A post-test to evaluate knowledge gained is administered at the end of the session.

Parent Sessions

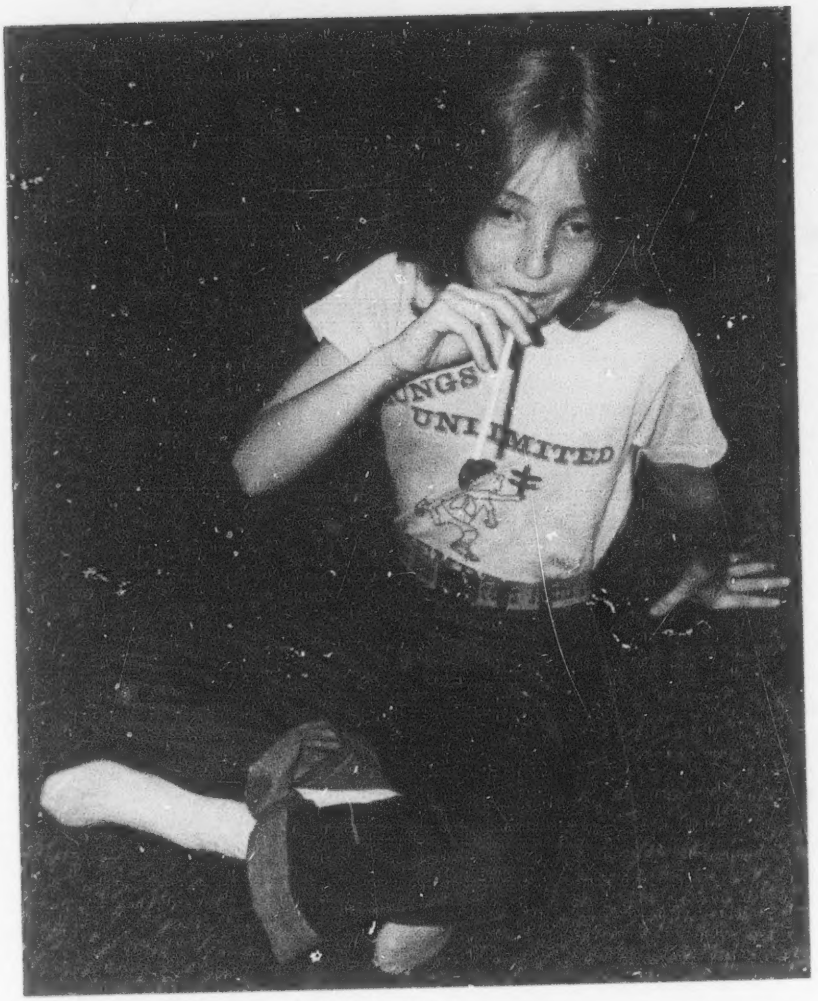
LUNGS UNLIMITED for parents follows a lecture/discussion format with various guest speakers from allied health and education groups. Each family receives supplemental material which complements each session.

The first session for parents teaches the self-management techniques that the children are learning. Other sessions feature presentations and discussions on the clinical aspects of asthma, medication used in the treatment of the disease, environmental control and the psychological and psychosocial aspects of asthma.

A graduation ceremony and social hour for both the parents' and children's groups concludes the sessions.

Evaluation

Reports from parents indicate that the program has had a positive impact on reducing children's asthma-related school absences, hospitalizations and visits to



Breathing exercises are taught in the program.

physicians and emergency rooms. For example, parents of 60 children report that a year after their participation in the program, children's visits to emergency rooms had decreased by 82 percent, compared to the year prior to participation in LUNGS UNLIMITED.

Parents of the same children also report that asthma-related visits to physicians' offices had decreased by 74 percent, school absences by 40 percent and hospitalization by 11 percent.

A recent study by the company that insured the families of some of the children has validated the significant reductions in the children's hospitalizations and emergency room visits.

Both parents and children also report positive outcomes in terms of decreased fear of asthma, increased self-confidence in managing the disease and increased family interaction as a result of program participation. Many children have told us that they now have a better understanding of what is happening to them and that they are less frightened of an attack because they know what to do—relax, do diaphragmatic breathing, drink warm fluids and take their medicine.

In an evaluation report completed six months after her family had participated in the program, one mother noted that her 12-year-old son felt more confident to handle attacks. "He doesn't get quite as upset as he used to," she wrote, and "he doesn't seem to be quite so embarrassed about his asthma." The mother also said that "it helped to know there are a lot of other kids just like him."

A parent of a 15-year-old boy wrote that he "was easier to talk with, listens better, not rejecting or defensive, especially to advice from authority figures." Another parent commented that a social worker said the program had been "very helpful" to her 10-year-old daughter.

According to the parents' evaluation reports, the program has also had a positive impact on other children in the family. One parent noted that her two non-asthmatic children now practice relaxation along with their brotner.

Another parent wrote, "Jonny's sister Ellen understands more about what is happening when her brother is having difficulty breathing. She coaches him with his diaphragmatic breathing."

"Leslie seems more patient with Lynne and her asthma since she attended LUNGS UNLIMITED," one parent reported. "She realizes that Lynne is not pretending or trying to get attention."

Conclusions

We believe that the project outlined here can serve as a basis for a family asthma education program in many different communities.[5] Future plans include expanding LUNGS UNLIMITED to include special programs for preschool children and for adolescents. ■

[1]Hugh Evans, "What Happens When A Child Has Asthma," *American Lung Association Bulletin*, July 1976.

[2]Hyman Chai, "Management of Severe Chronic Perennial Asthma in Children," *Adv. Allergy Asthma*, 2:1, 1975.

[3]Hyman Chai, a presentation included in the proceedings of *A Clinical Symposium for the Primary Care Giver*, Perrysberg, Ohio, Jan. 31, 1981.

[4]D.S. Reddihough, et al., "Family Anxieties in Childhood Asthma," *Austr. Pediatrics Journal*, 13:4, 1977.

[5]Additional information on materials used in the program may be obtained from Janet Bruggeman, Program Director, American Lung Association of Northwestern Ohio, 520 Madison Ave., Suite 225, Toledo, Ohio 43604.

KIDSPACE:

Family Life In The City

by Vivian T. R. Barry

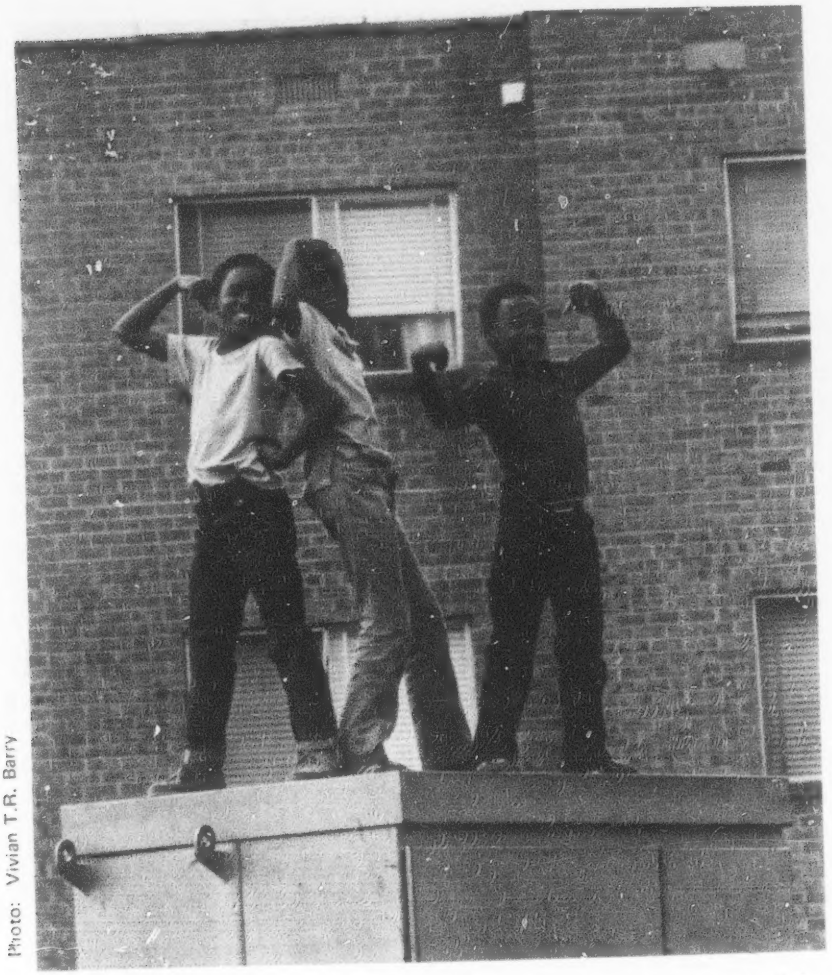


Photo: Vivian T.R. Barry

"On top of the world," on a transformer box in front of an apartment building.

Where did you like to play when you were five, 10, 15 years old? When did you first ride on public transportation without an adult? Where and with what did you build a fort or a clubhouse? Do kids you know have comparable places to play today? Does today's urban environment meet the needs of families you know?

Although significant research on children and families has been conducted, building developers and government policymakers have applied few of the findings of child development specialists to housing design, neighborhood revitalization or land use planning. Using methodologies developed by those working in environmental design research, however, an observer can see how city space can be organized into related elements.

Two years ago, I looked at some urban areas of Washington, D.C., studying city design and the behavior of children and families in neighborhoods—and their relationship. The observations were done by a random sampling within neighborhoods, but they cut across economic, geographic and ethnic groups. I also searched through pictorial records of the city to discover uses and sites that have been abandoned but which might have relevance to the present. My observations were organized into three areas: "Hometurf," "Streetstuff" and "Out and About," the topics around which the resulting exhibition, KIDSPACE (see accompanying story), is arranged.[1]

Hometurf

Toddlers first begin to play independently right around the outside of their home. Here preschoolers, after the close ties of infancy, can begin to gain independence and self-reliance within enclosed, secure front or back yards. They may also see the passing world of their neighbors, encounter postal carriers and other service people and watch vehicles of various shapes and sizes go by.

A well-designed house and yard permits freedom for the adult to attend to work within the house while maintaining a view of the outside activities of the children in a fenced-in yard. Caregivers can observe the children at play without interfering or stifling spontaneity by too close supervision.

Room for outdoor play in an ob-

Vivian T.R. Barry, an urban planning consultant in Washington, D.C., directed the Community Design for Family Use Project and the resulting exhibition, "KIDSPACE." *© 1982, Vivian T.R. Barry.*

servable area around the house can be especially useful in dangerous neighborhoods. We've been told by 8- and 9-year-olds living on a block of row houses with front and back yards that their parents did not let them go to a playground just two blocks away. In fact, on one sunny fall afternoon, this particular playground was virtually deserted except for a few basketball players and marijuana smokers.

In apartment complexes in Washington, courtyards are significantly more utilized than any other site element. Across the city, children of all ages use their courtyards. They play primarily with others of their own age but we have observed that children also watch older age groups for a look at the future. Older kids pass on the folklore of the region and the rules of the games: they teach by example what will be required in their culture and society.

As playgrounds deteriorate in the urban core and are increasingly scarce in the outlying suburbs, children return to their Hometurf to play outside. Responsive design of multifamily dwelling units should incorporate an on-site focal point of activity for children: a well-defined, semi-protected open area with climbing and/or other equipment of the kind usually found in playgrounds.[2]

The alleys of residential city blocks can be protected thoroughfares for tricycles and bikes and the way to first independent visits to neighbors. In a 1967 study, the urban designer, Lawrence Halprin, proposed creative uses of these block interiors. He designed interior parks utilizing parking spaces, storage areas and some portion of private backyards.[3] (We don't know of any blocks where these designs have been implemented.)

Streetstuff

Moving into the streets and sidewalks, we found kids and people engaged in unusual activities in ordinary places and vice versa! A sedate stone statue was a small mountain to be scaled. A curb was used for sitting while eating ice cream cones. There was an outdoor living room in a vacant lot, complete with armchairs, newspapers and a fireplace/oildrum. A stack of tires had been turned into a single occupant hut with a cloth roof; scrap wood in another vacant space provided an afternoon of work for young aerospace manufacturers. Sidewalks were being used for chalk drawings, as a race track for bikes or roller skates and for basketball dribbling, cheerleading practice and the autumn sport of kicking leaves. If kids are lucky, a block might contain a public phone built for the handicapped. Children are also well served by its low height. The presence of public clocks and time-keeping church bells help kids maintain responsibility for their own schedules.

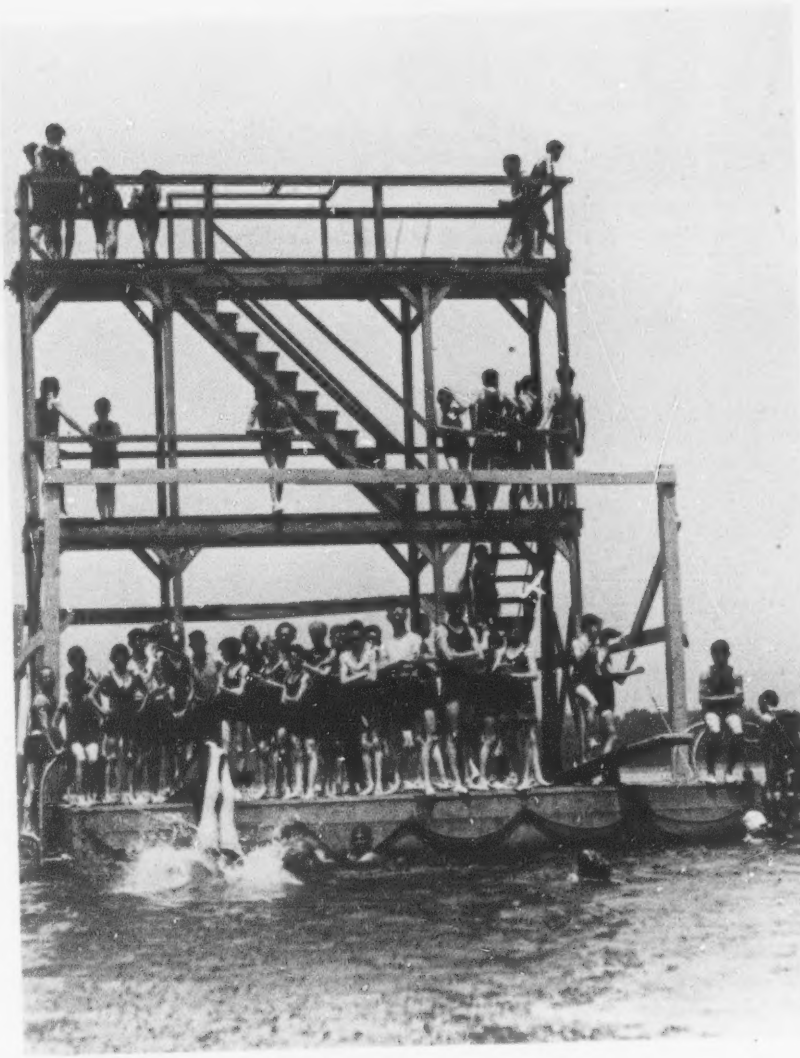


Photo: Library of Congress, French collection.

Diving platform, Potomac River, 1923.

Other urban goodies that are fading from community life are office and storefront windows which reveal interesting activities and provide kids with a choice of role models and goals for jobs. The old sidewalk bench is almost extinct. Outside of parks, benches these days have been spotted in front of laundramats and, rarely, outside small corner drug stores. If comfortable space where people can meet is not provided, community life suffers by the isolation of its members, both young and old.

Out and About

Kids don't travel far for their regular

Photo: Carl Mydans, Library of Congress.

Playing cards in a front yard near Union Station, Washington, D.C., 1935.

after-school and weekend play. Large parks with huge open vistas are not used regularly by kids. The immediate neighborhood is where they are going to spend most of their time and it is the neighborhood that needs to plan for its kids.

The neighborhood corner store is fading from the picture. Mom and Pop, who used to own the candy or grocery store, can't make a living fighting crime and inflationary real estate values. It is the neighborhood's loss. Zoning and tax incentives need to incorporate the human scale of neighborhoods through plans for mixed commercial residential use and the support of small businesses. Where the corner store still exists, we have seen it as a magnet for all members of the community. Kids like to play and hang around these corners to meet friends and exchange news. In some places, these stores still provide such first jobs for kids as stock-clerking and making deliveries.

When summertime comes around, the folly of pollution in the waterways of our cities becomes most apparent. By 1981, the city of Washington, D.C., was closing several of its public pools. This would not be such a community loss if the rivers were clean enough for recreational use. Still available for sports, family activities and picnics are school playing fields, after hours and on weekends and holidays. There are also ice skating rinks and outdoor markets, which may be exchange points for homemade goods, gossip and sometimes a performance by a theatre group. Some community centers still operate and provide activities and help for city families.

The placement of such services as child and health care and job training and educational assistance needs to be considered by the city and local community. The pros and cons for job-site day care versus neighborhood centers or family day care should be discussed publicly by

planners and parents so that choices best suited to community needs may be offered.

Finally, we noted that job opportunities for kids are an urgent and vital need. Perhaps, through the rise of private sector interest in urban enterprise and revitalization, some new approaches to this major problem will be created. Fostering the growth and development of productive and valued citizens is part of the city's function in every family's life.

The questions directed to the reader at the beginning of this article are designed to help both laypersons and professionals use their own experiences in evaluating today's urban life. Our premise is that for a majority of the urban population, city life was indeed more "livable" 20, 30, 40 years ago. Through recollection and analysis of the childhoods we know intimately, we can gain a sense of continuity and perspective for a critical look at today's communities. Nostalgia may yet be used as a grass roots political tool.

Sound urban planning and design can strengthen and support families and diminish the social and personal troubles of children and youth. This kind of planning includes the provision of adequate and safe play spaces around the home and in the streets, sidewalks and open spaces. It includes commercial services and public transportation that facilitates the beginning of children's independent interaction with the adult world of goods and services.

Public services and facilities must be appropriate for the community's citizens. City recreation departments must reassess urban densities and the need for and value of separating out children's activities—from the neighborhood's more homogeneous spaces—and fencing them in with steel and concrete playgrounds. And since summer and snow are special for kids, good planning considers how the landscape can be used for seasonal activities.

A "liveable" city has room for children to explore and create. Adventure is an essential part of a child's development. Part of the work of kids

KIDSPACE

"KIDSPACE: Using The City" is a 14-panel exhibition about children, family life and the urban environment. Through 95 photographs, maps and drawings, it offers both an historic and a contemporary look at one city's neighborhoods.

The exhibition developed from a study, the Community Design for Family Use Project, which began in 1980 with funding from the D.C. Community Humanities Council, the National Endowment for the Humanities and the D.C. Commission for the Arts and Humanities. Sponsored by The Catholic University of America and the American Planning Association, the project and the exhibition were directed by Vivian Barry.

KIDSPACE surveys a variety of Washington, D.C., neighborhoods and examines how they are functional for children and the adults with whom they live. It demonstrates various past and present design concepts that benefit or hinder families and it looks at how neighborhoods can foster support systems, such as those found with friends and neighbors. Housing site design, density and scale; the relationship of housing (both public and private) to open space; children's outdoor activities; and commercial services, including jobs for kids, public services and playgrounds, are highlighted, as are also the roles that such community establishments as churches, neighborhood houses and after-school facilities can play.

The exhibition has been shown at the Capital Children's Museum and other sites in Washington, D.C., the American Planning Association in Boston and will travel to New York City, where it will be on view at Hunter College in September. When it is not traveling, the exhibition is housed, and on view to the public, at The National Center for Family Studies, The Catholic University of America, Washington, D.C.

The next study planned by the Project is a parallel view of suburban family life. ■

Photo: Vivian T.R. Barry

Left: On their way home from the store, mothers and children relax in a Capitol Hill park in Washington, D.C. Below: Tires are usually safe--and fun--to play with.

Photo: Vivian T.R. Barry

is to define and forge their role as citizens. Self-reliance, independence and responsibility are affected by the urban environment and great cities provide space to accomplish this development. ■

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[1]The study, the Community Design for Family Use Project, began in 1980 with funding from the D.C. Community Humanities Council, the National Endowment for the Humanities and the D.C. Commission for the Arts and Humanities. Sponsored by The Catholic University of America and the American Planning Association, it produced the exhibition, *KIDSPACE: Using The City*.

[2]The landscape architecture firm of Coffin and Coffin in Washington, D.C., was hired to produce a design for Barry Farms, a low-income public housing project. There, the D.C. Department of Recreation built a range of excellent outdoor facilities that are now well utilized by the children and adults living there. Within an approximately 3-block area with little vehicular traffic, there are jungle gyms and sandboxes; a basketball court, a field for football, soccer and basketball, all behind a public school adjacent to the housing project; a public swimming pool, also adjacent to the project; picnic benches; and open space for roller skating, bike riding and imaginative play. Smaller open spaces work as courtyards and focal areas amongst the rows of project housing.

[3]*A Report from Lawrence Halprin & Associates To Mrs. Johnson's Committee For A More Beautiful Capital*, January 1967.

Riding the Metro: Rhode Island Avenue Station, Washington Metropolitan Area Transit.

Bringing Children To Work:

by Carolyn Reece

The need for day care for employees' infants was met when the Mt. Vernon day care center opened.

"I love it!" Nancy Adams replied when asked how she liked taking her 15-month-old daughter to work with her.

Adams is a recovery room nurse at Mount Vernon Hospital in Alexandria, Virginia, where a day care center for employees' children, aged six weeks to eight years, opened in January. A first-time mother, Adams likes "being able to drop in and see Kristina during the day. It's reassuring to see that she's being well cared for, and I can really get a 'feel' for what's going on."

The peace of mind that comes from knowing your child is nearby is high on the list of advantages parents cite for having day care available at work. Convenience is another. "I don't have to make a special trip to drop Michael off when I'm rushing to get to work," points out Mark Ziser, a pharmacist.

For employers, the provision of day care can be a plus when it comes to recruiting and retaining skilled workers. Due in part to the shortage of nurses, and to the high percentage of young women in nursing and other areas of medical work, hospitals have been in the forefront of em-

A Hospital Day Care Center

ployers offering day care. According to a study published by the Women's Bureau, more than three-quarters of the civilian employer-sponsored day care centers identified in 1978 were operated by hospitals.*

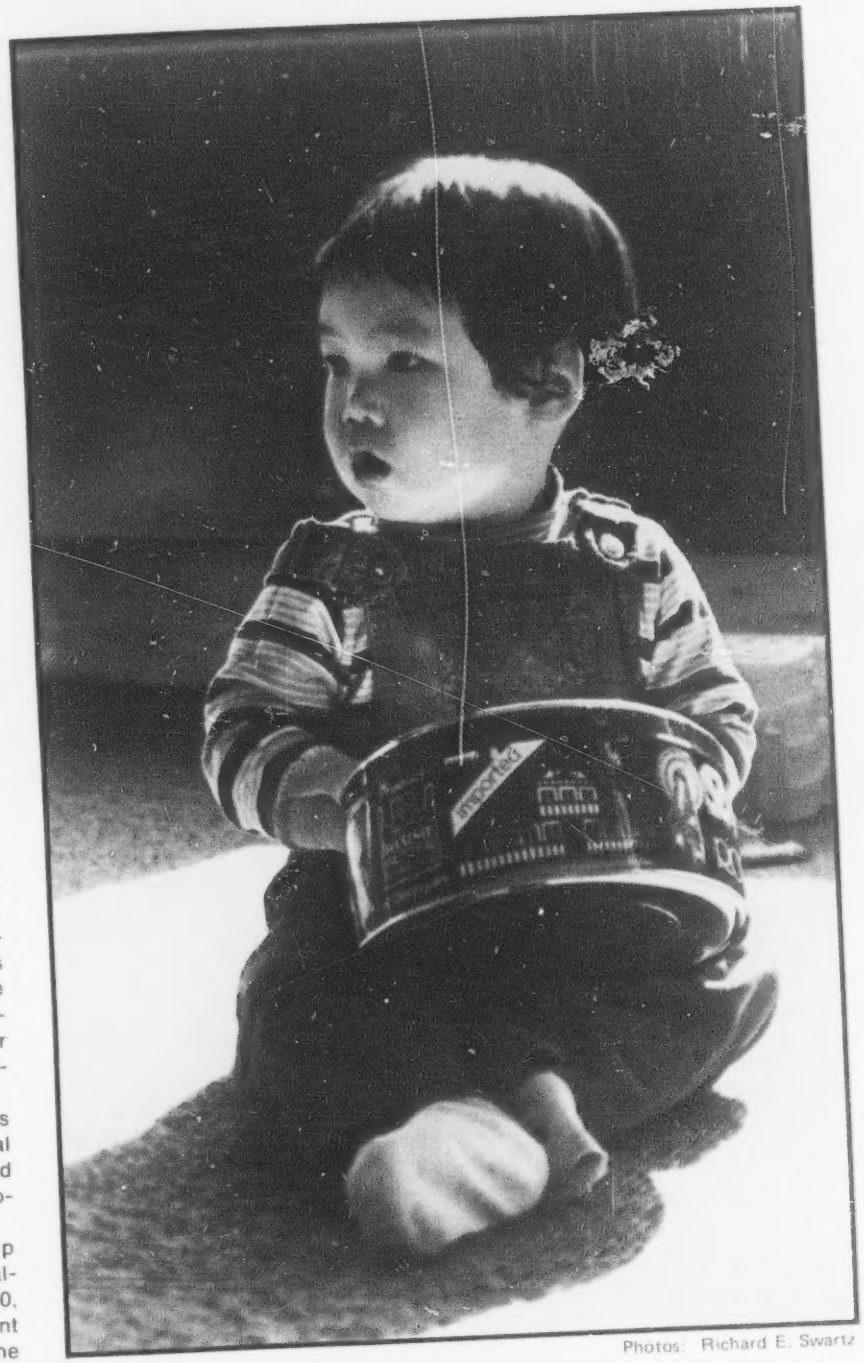
At the 5-year-old Mount Vernon Hospital, where 80 percent of the 800 employees are women of childbearing age, the day care center offered a practical solution to meeting the needs of both employer and employees.

Like many hospitals in the area, Mount Vernon had been experiencing problems in attracting and keeping highly trained nursing and technical staff and in scheduling shifts. Early in 1980, Mount Vernon and the two other hospitals operated by the Fairfax Hospital Association discussed plans for an Association-sponsored day care facility. Because of the distances separating the hospitals, however, it was not feasible for one program to serve all three.

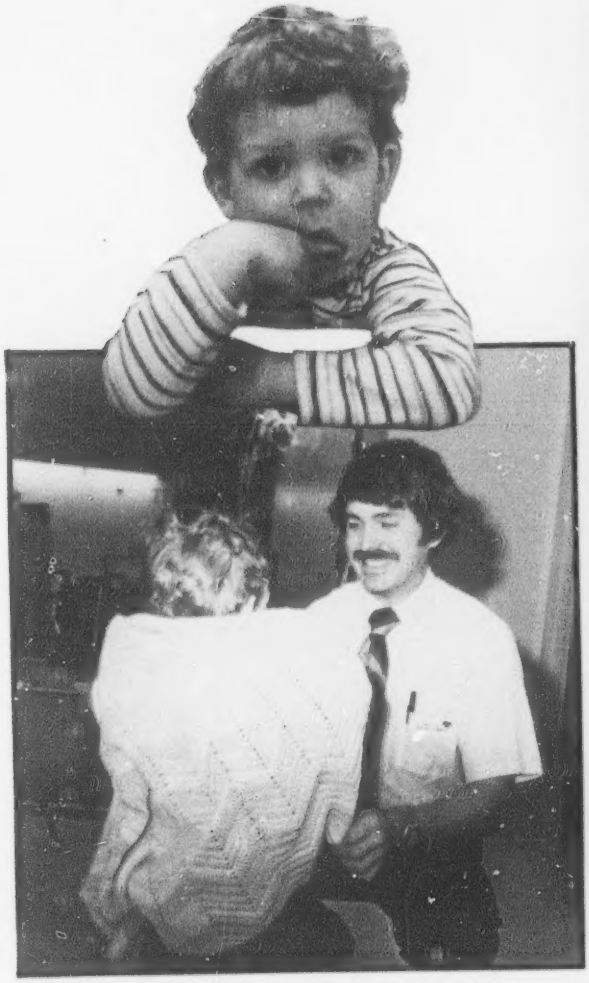
Later that year, an administrative resident at Mount Vernon researched various day care options—on-site care, purchasing slots for employees at a private center and using a system of satellite day care homes, for example—and did a preliminary survey to determine employees' needs. A second survey early last year revealed that the need for day care was "even more overwhelming than we had suspected, particularly for infants," said Mary Howland, director of the community relations department.

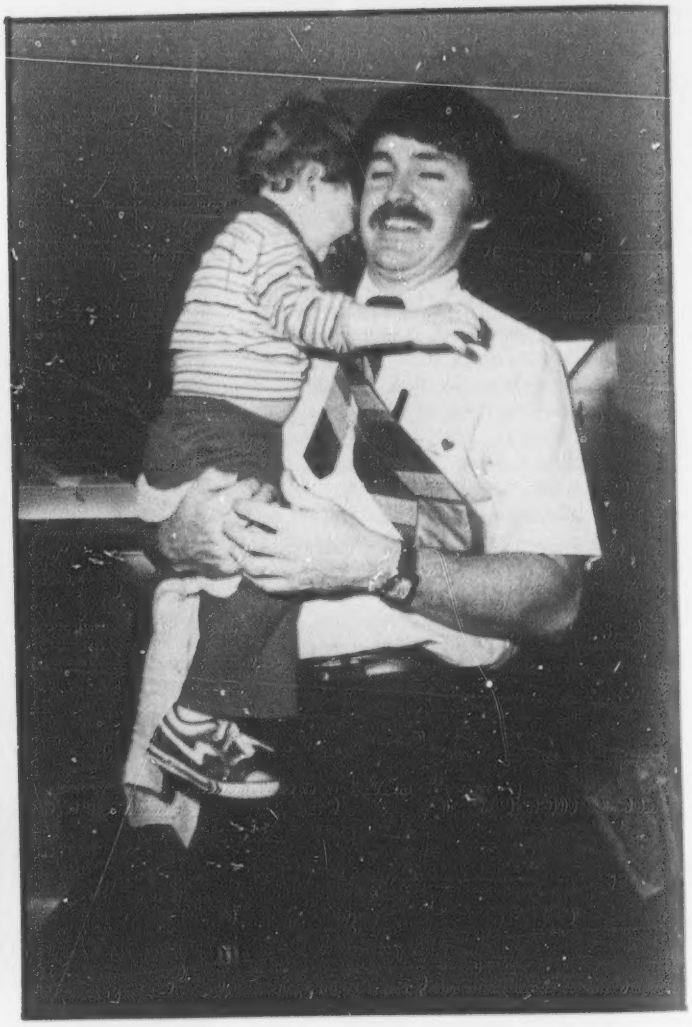
After examining the survey results and considering the options, hospital administrator Stephen Rupp backed a plan for an on-site, hospital-subsidized day care center.

"It's not inexpensive," Rupp acknowledged. Start-up costs, although modest, were about $15,000, and the hospital made a commitment to subsidize 25 to 30 percent of the



Photos: Richard E. Swartz





Mark Ziser drops by the center to visit with Michael.

costs of operating the center 12 hours a day (7:00 a.m. to 7:00 p.m.), five days a week, including breakfast, lunch and dinner, plus snacks, each day. Parents' fees were recently raised from $11.00 to $12.00 a day (prorated for those using the center less than full time), prices that are comparable to day care center rates in the northern Virginia area.

"In the long run, though," Rupp believes, "the center will help to reduce our overall costs. Job turnover and absenteeism are lower, and having the center there enhances the ability of women on maternity leave to come back to work quicker."

The center "definitely gives employees peace of mind," Rupp says—and makes for happier employees. And it's not only the employees whose children are enrolled who appreciate having the center there. Many hospital workers come in regularly just to enjoy the lively, healthy children—and supervisors need not fear that a "pool" nurse won't be available because she can't find a babysitter.

Planning for the center began last July, when Frances Damico was hired as director. Working closely with other hospital staff members, she developed a budget, established policies, met with interested parents and worked to convert a vacant 5th-floor wing into a cheerful and efficient day care center. Damico also persuaded Betty Sanborn, whom she had worked with previously, to become the new center's infant specialist.

With the start-up funds, Damico and Sanborn purchased some sturdy, versatile play equipment, cribs and infant supplies and cots for older children (supplemented by mattresses and pads from the hospital). From Sanborn's design, hospital engineers constructed movable, open room dividers from plastic piping and painted them in bright colors. The nurses' station was turned into a handy storage/work area, and a sunny area along one wall was carpeted and partially enclosed for toddlers and crawling infants.

Rooms leading from the station were set up for sleeping, reading stories and other quiet activities. One remained as a hospital room, with a bed, IV equipment, stethoscopes and other hospital supplies in it, to

encourage children to role-play their parents' occupations. A nurses' lounge became the Parents' Place, where parents and staff members can relax and talk, or browse through materials on infant care and child development.

Flexibility in programming was an important consideration, since the center had to accommodate a wide age range of children who come and go throughout the day depending upon their parents' schedules, or who attend only two or three days a week if their parents work part time.

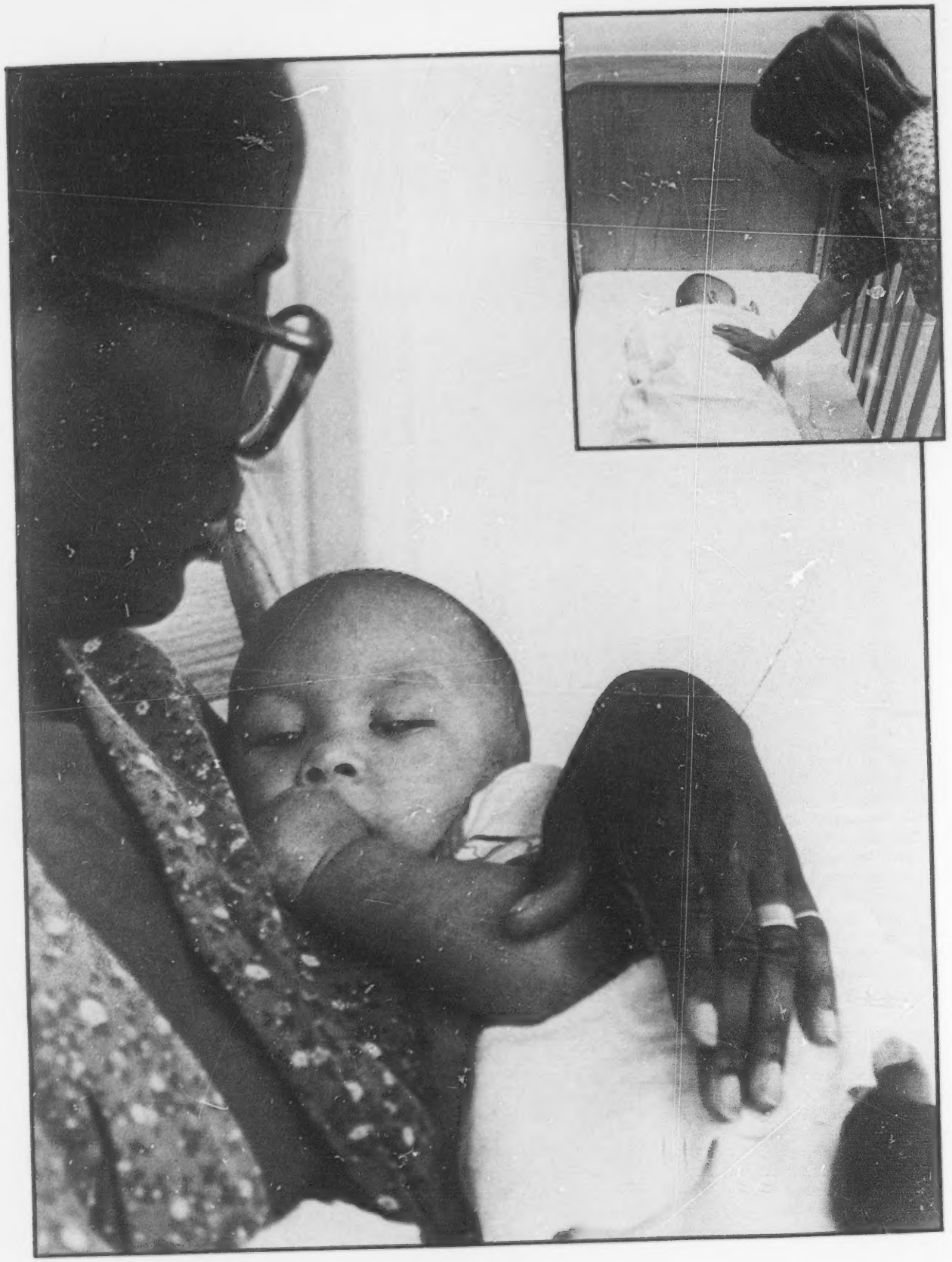
That the center operates so smoothly, with no noticeable disruption to ongoing activities, Damico attributes to her staff: experienced and well-trained caregivers who are committed to her goals of providing support to families and enriching social, physical and intellectual experiences for even the youngest of children. The 10 permanent staff members—four of whom hold master's degrees in early childhood education—are supplemented by adult and teenage volunteers, arranged through the hospital's volunteer office.

In fact, it's the "warmth," "love," "caring" and "individual attention" that parents cite first as the center's most important and satisfying aspects. "It's much more than baby care," says Ziser, who has noticed a "marked improvement" in 2½-year-old Michael's socialization skills since he began attending a few months ago.

Nancy Adams, who currently uses the center only one or two days a week until she returns to work full time, is impressed that caregivers remember Kristina's daily routine and can ease her comfortably into the center's. Harriet Hoben, a medical transcriptionist who works the 3:00 to 11:00 p.m. shift, is happy that Danny, a 1st-grader and one of the oldest children enrolled, has an opportunity to assume a helping role with staff members and the younger children.

One of the most popular features with parents are the written reports staff members send home every day, capsuling the highlights of each child's day. Infants' feeding and changing times are given, and narratives point out social and develop-

A hospital volunteer helps support a young climber (top) while a caregiver enjoys water play with preschoolers.



Scenes from the Mount Vernon Hospital Day Care Center

mental milestones the children are attaining—"It looks like Jason is about ready to walk," for example.

Currently, the center enrolls 94 children of 74 employees. So far, there have been few requests to extend the hours of daily operation or to keep the center open on weekends. Should there be a demand, however, Damico will try to accommodate parents.

There is also the unresolved problem of transporting children who need after-school care from their schools to the day care center. Hoben manages by bringing Danny and Ricky, who is in kindergarten, with her when she reports to work at 3:00--and either her husband or 18-year-old son are available to pick them up when they finish work. The hospital is investigating after-school and expansion possibilities with some of its neighbors, including a community mental health center and medical and professional office buildings.

Damico believes that employers have a "moral obligation" to see that children are cared for. "If employers cannot afford to operate a facility, they can at least offer space and let the center pay for itself," she points out. "The time has passed when parents have a choice about working, and hospitals, in particular, should have a commitment to helping children and families."

The support, interest and commitment to the center from all departments of the hospital have been, Damico says, "outstanding." And, she notes, "We don't have 'parent relationship' problems. The center is right here—we encourage parents to come in and see their children and what we do with them. There's a feeling that we're all part of the same Mount Vernon Hospital family." ■

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*Kathryn Senn Perry, *Child Care Centers Sponsored by Employers and Labor Unions in the United States*, Women's Bureau, U.S. Department of Labor, 1980.

A Pediatric Counseling Service

by Carol Klein

In this era of the isolated nuclear family, where can parents turn to receive the information and support they need to do a good job of raising their children?

In Chapel Hill, N.C., they turn to a child management and counseling service which is staffed by a group of specialists from the University of North Carolina and functions out of the office of four local pediatricians who provide care for more than 10,000 of the community's children.

The service is administered by the Division for Disorders of Development and Learning (DDDL) of UNC's Child Development Institute, a training facility which draws upon the resources of 12 health disciplines focusing on developmental disabilities and learning disorders. Counselors for the service speak with parents about a wide range of life situations, including divorce, adoption, sickness, death, moving away and sex-related problems.

The program involves a phone-in hour two days a week, private consultations, and parent education group meetings. Anyone, whether or not they are patients of the four pediatricians, can use the service.

Carolyn Schroeder, head of the Psychology Section of DDDL, initiated the service in May 1973 because she believed that the pediatric office is the best place in which to provide preventive education and immediate counseling for parents in the community. "Parents regularly take their children to the pediatrician, especially in the early years," she explained, "and it is natural for them to discuss issues of psychosocial adjustment in this setting."

The professional mental health staff and the pediatricians are able to consult regularly about the children's physical and emotional progress.

Dr. Charles Sheaffer, one of the four pediatricians, agrees. "We used to feel frustrated," he said, "because we weren't able to deal with all of the questions that parents ask. Now we feel confident that they are receiving the information they need to help their children." Dr. Sheaffer and Drs. William Conley, Meade Christian and Jennifer Lail form the only private practice pediatric service in the city of Chapel Hill.

Dr. Schroeder added that "parents are more comfortable coming here to discuss initial concerns than to a mental health clinic, and they are more apt to believe in the credibility of the person offering help when the pediatrician has demonstrated his or her confidence in that person."

She said, too, that the collaboration is both practical and advantageous because the professional mental health staff and the pediatricians are able to consult regularly about the children's physical and emotional progress.

That the clinical psychologist and other mental health specialists have something unique to offer in the health care field has long been recognized, according to Dr. Schroeder. In 1968 the Society of Pediatric Psychology was created to provide a forum in which psychologists might share their experiences in service, training and research with primary care physicians. And the Department of Health, Education and Welfare, in its Forward Plan for Health for 1978-82, called for the development of liaison arrangements between primary health providers and mental health professionals.

As an associate professor in UNC's Department of Psychiatry, Dr. Schroeder was also seeking an opportunity for students who were training for professions that deal with developmental disorders. The students needed more opportunities to observe the normal course of a child's development. "Often," she said, "these students felt that specific behavioral problems were unique to the handicapped population."

In the counseling program, pediatric and psychology interns and graduate and post-graduate students in psychology, social work and nursing can learn more about the concerns of parents, and how to respond to them most effectively, said Dr. Schroeder. She added that a recent grant to UNC's Department of Pediatrics from the National Fund for Medical Education has made it possible for all pediatric residents in the medical school to become involved in the program as a part of their training, with each resident spending one day a week for a month observing and participating in counseling sessions.

The sessions are staffed by a team of five counselors from DDDL—social workers Blan Minton and Elaine Goolsby, nurse Marva Price, psychologist Betty Gordon and Dr. Schroeder. The telephone counseling is limited to about 15 minutes and is free. Staff members recommend a consultation by appointment if a call lasts much longer than 15 minutes, if a parent calls repeatedly about

Carol Klein is a science writer in the communications office, Frank Porter Graham Child Development Center, University of North Carolina at Chapel Hill.

the same problem, if a problem is out of the particular staff member's area of expertise, or when the parent is alarmed. Problems which involve negative behavior across a number of situations such as refusal to eat or go to bed, or to comply with even simple requests, often require more extensive help than can be given over the phone. One or both parents may then be seen, with or without their children. All proceeds of a $45-an-hour charge for appointments are given to a student each year who is involved in the program.

Parents have also requested help. . . because they want to increase their knowledge about child behavior in order to become better parents, and to prevent future difficulties.

In the nine years of its existence, the service has received more than 3,000 requests for guidance. A log is kept of all calls and visits, and the program receives ongoing evaluation. Parents are asked if they may be contacted in six months to find out if the guidance has been effective. Parents indicated that it is helpful to hear "what to expect" at various ages. They found most helpful those staff responses which focus on the child's positive behavior, and the use of alternative methods of punishment, such as isolating a child for a time.

During phone calls or come-in appointments, Dr. Schroeder explained it is important to note the parents' affect, and to give verbal feedback to the parents' feelings. A counselor might say, "It sounds like it is difficult to be home with two preschoolers." Or, "A child crying all night is upsetting."

A variety of intervention methods are used to modify behavior. The counselors may teach the child or the parent new responses. They may attempt to alter the parents' expectations, attitudes or beliefs. They may suggest changing the environmental cues that set the stage for the behavior, changing the emotional atmosphere that surrounds the behavior or changing the consequences of the behavior for the child.

"We do not give canned advice," Dr. Schroeder stressed. "Instead we share ideas and work with the parent to find a solution. For example, in the case of a 4-year-old who was fearful of helicopters and who lived near a helicopter base, we put the fear in perspective by informing the parent about the common fears of 4-year-olds. Then we discussed what might be done to help the child, such as desensitizing him by reading about helicopters, and visiting the helicopter base but remaining in the car."

When the counselors determine that the behavior may be severely disturbed or dangerous, they refer the child for more intensive treatment. A child whose behavior could cause significant physical harm to himself or others, or serious property damage, is at high risk, said Dr. Schroeder, and should receive treatment from an appropriate professional. Developmentally delayed children require services beyond the scope of what can be provided in the pediatric office. Schroeder estimated that 12 percent of the cases are referred to other agencies.

Most parents are not looking just for support, Dr. Schroeder reported. "They want specific guidelines and techniques for problem solving. They want to know how to give commands, and how to follow through effectively. The counselors can relieve many problems simply by providing information about child development. For instance, it is not uncommon for parents to measure their children's progress against that of the neighbors' children. One parent complained because Gregory was two years old and not talking, while little Raymond next door 'talks a blue streak.'"

Or parents will compare siblings. "My Heather's such a sweet child," one mother observed, "but Holly's a terror. Why can't Holly be more like Heather?"

Parents are helped to accept differences among children in temperament, endowment and developmental patterns. And they are told that certain stresses and susceptibilities are associated with particular growth stages, that a child of three, for instance, may be calm and pleasant, while the same child at age four may be cranky and whiney.

Dr. Schroeder added that it is sometimes difficult for a parent to know what language to use in talking to a very young child, and therefore, how to gear expectations to the child's developmental level. One phone call illustrates her point.

"I tell Johnny, 'you be quiet, now. Your daddy's working on his dissertation.' But Johnny doesn't pay any attention to me. He just keeps right on making noises."

"How old is Johnny?" the counselor asked.

"He's two and a half."

"Then it's probably quite difficult for him to understand what the word 'dissertation' means, or the importance of being quiet so Daddy can complete it. He's also at an age when being quiet is especially hard. Perhaps letting him know what he can do, such as playing with blocks in his bedroom, or simply saying 'no screaming in the living room' would work best."

Dr. Schroeder believes that the trust built up between caller and counselor over a period of time is an important

factor in the program's success. Chapel Hill resident Susan Hailey has said, "It's nice to know the service is there, even when you don't use it. If a problem does come up for which you can't find a solution, all you have to do is pick up the phone."

Not long ago a mother did just that—she picked up the phone in the middle of the night. Her husband had just died of a lung disease. She was anxious to know how to explain his death to her 3-year-old son. Dr. Schroeder said, "She had called me twice before to ask about the effect on her child of her husband's illness, but I never saw her personally. I asked how she was, if she had any support, and if she had called the doctor. Then I suggested that she at first tell her child only that his father was very sick, that some people would come, and his father would have to go to the hospital. The child had seen this happen before. Later she could explain the death by saying, 'Daddy was very sick and he has died. That means he won't be able to talk to us or be with us anymore but we'll always be able to remember him.'

"I advised her to explain everything on a concrete level, leaving as little as possible to the child's imagination. I told her that he might go right on playing, so that it will appear that he doesn't care. But this is how a 3-year-old might handle such a big subject. It was important that she bring it up and allow the subject to be discussed as her child was able to discuss it."

Help such as this at times of great stress has not gone unnoticed among Chapel Hill parents. Over nine years' time, countless parents have relied on the service in similar, though perhaps less dramatic situations. Other parents have learned about the service from the local newspaper, the Welcome Wagon group, and notification in the pediatricians' billing system. Mostly they have learned of it by word of mouth. The service has become so well-known that parents have also requested help, not because of an immediate problem, but because they want to increase their knowledge about child behavior in order to become better parents, and to prevent future difficulties.

In response to this, the service began a schedule of evening group sessions on the development and management of children from the age of one week through adolescence. The emphasis is on how children develop and learn. Groups meet for one 2-hour session a week, and all sessions are free. Each includes a presentation and discussion of one subject such as toilet training, discipline, sibling rivalry or a particular age group. The leader facilitates the problem solving process, Schroeder said, by providing a perspective on the child's development, and how this fits into learning new tasks and skills.

Dr. Schroeder noted how the service in some ways has changed during the past decade, and how in other ways it has remained the same. "The staff's ability to deal quickly and effectively with a variety of issues has increased," she said, "but the complexity of the questions and concerns parents bring to the service remains a challenge."

She said concerns about the effects of divorce, separation and custody increased from six percent in 1973-76 and 1977-78 to 11 percent in 1978-79. The change in custody practices, she said, is reflected in more questions about the effects of joint custody on children. The professionals involved in answering questions about divorce and separation require an understanding of children's needs, as well as skill in working with the hostility felt and projected by parents towards each other.

"Helping parents see how the anger affects their children's relationship with the other parent," she said, "is as important as setting up the most desirable living arrangement for children. Also, considerable skill is needed to assess a child's understanding of what is happening."

Evaluation of the service has revealed that concerns regarding developmental delays were most often centered on preschool children (46 percent). Dr. Schroeder said, "The concerns centered on motor, cognitive, social and language development. This information led to the establishment of routine screening in the pediatric office for 3-year-olds with the Denver Developmental Screening test. The screening session enables parents to get direct feedback on how the child is developing, and some parents no longer need the intermediary step of the Call-in/Come-in service. There has been a drop of concern in this area, from 11 percent in 1973-76 to six percent in 1977-78 and three percent in 1978-79.

Another significant change has been an increase in concerns about negative behavior. "This finding prompted us to attempt an early intervention program with 'negative' children and their parents," Dr. Schroeder revealed. "Now when a parent contacts us with a primary complaint of negative behavior with a preschooler, we try to see if the behavior occurs across many situations and is an indicator of more serious problems in the parent-child interactions.

"We offer the parents a one-hour-a-week, 6-week early intervention program that focuses on increasing positive interactions with their children and teaches them how to make and follow through on commands to them. Following the children over the next several years will allow us to say more about the program's long-term effectiveness."

Most recently, Dr. Schroeder said, a number of teenage girls have elected to use the service to discuss family problems and personal concerns.

A giant step for the service will occur next fall. While retaining her position on the UNC faculty, Dr. Schroeder will leave DDDL to become a full-time member of the pediatric group.

As a research scientist at UNC's Biological Sciences Research Center and a staff member at the Division for Disorders of Development and Learning, Dr. Schroeder has focused her work on training and research with the developmentally handicapped population. "Prevention and early intervention have always been a prime interest for me," she said, "and I look forward to the opportunity to develop more of these services within the primary care setting." ■

The Children of Working Parents

by Ann C. Crouter

How do parents' work experiences affect their children? Given the impressive number of studies that have addressed this question in the last 50 years, one would expect to have a substantial body of instructive and unequivocal answers.[1] Unfortunately, that expectation has not been realized because the question has turned out to be exceedingly complex.

Put simply, the answer is "It depends." It depends on who the parents are, who the children are, the circumstances of work, the quality of the supervision the children receive, the psychological meaning of work and family life to the persons involved, and, last but far from least, when the investigation was conducted.

One reason we do not have a more coherent picture is that researchers have asked employed mothers and employed fathers different questions about this issue, questions that reflect deep-seated notions about the appropriate sex-role activities of parents. As early as the 1930s, researchers identified the "working mother" as a social problem. Studies between 1930 and 1960 emphasized the negative effects a working mother had on her children. Poor school achievement, delinquency and poor social adjustment were just some of the problems researchers identified as more serious among children of working mothers during this period. Many of these early studies, however, had serious methodological flaws (for example, failure to control for social class) that called into question the validity of the conclusions.

Some of these flaws were rectified in a series of more sophisticated studies conducted in the 1960s and 70s by Lois Hoffman and others. These studies came to a common conclusion: *the fact that the mother works has no universally predictable effect on the child.* The factors that did make a difference, they said, were the age and sex of the child, the family's position in society, the nature of the mother's work, and her attitudes toward it.

One of the clearest patterns to emerge in a variety of studies conducted in both the United States and Canada is that results vary depending on the sex of the child and the family's social position.[2] There is growing evidence that having a mother who works outside the home can be beneficial for girls. These girls are more likely to admire their mothers, to have a positive view of being female, and to be more independent than their peers whose mothers work at home. The pattern does not hold for boys, however. In middle-class families, sons of employed mothers perform less well in school than boys whose mothers work at home. Interestingly, this pattern does not hold for low-income families, perhaps because the income brought in by the mother is so important to the family economy that it offsets any negative consequences her working might have for her sons. The picture is still far from clear.

It is worth noting that most of these studies on the employed mother focused almost exclusively on the child. We know virtually nothing about the mother's workday, what she learns at work, and what working means to her. We also have no picture of what she is like at home, what

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Ann C. Crouter, Ph.D., is an assistant professor of human development, Pennsylvania State University. *Her article is reprinted, with permission, from* Human Ecology Forum, *Winter 1982.*

Research on the impact of the Depression on children's development shows the "importance of examining the interrelationship between work and family." Right: Unemployed men, circa 1933.

family activities take place, or how daily life in her family differs from that of a family in which the mother works at home. It may not be the mother's *job* that is the key difference, but rather the family's ability and opportunity to find high-quality care and supervision for the children, as Eleanor Maccoby cogently pointed out in a critical review written in 1958.[3]

Where do fathers fit in this crazy quilt of research findings? Because researchers interested in working mothers focused primarily on the child rather than the family, the father did not appear as a central, important figure. Rather, fathers were the focus of separate research that examined the effect of work and work environments on men. On the whole, researchers emphasized men's provider role rather than their parenting role. Thus, we can only infer what effects their work has on their children. Again, a brief historical foray is instructive.

The first studies, carried out in the 1930s, explored the impact a father's *loss* of work had on his family. In general these studies revealed that during the Depression the unemployed father lost status in his family, that family tensions and arguments increased, and that social life outside the family decreased.

Another major theme in this early research was the impact the nature of the work had on a father's parenting values and childrearing practices. Miller and Swanson, for example, distinguished two types of work organizations: bureaucratic and entrepreneurial.[4] The investigators showed that the wives of men in bureaucratic jobs (characterized by regular hours, security, employee benefits) emphasized interpersonal skills and getting along with other people in their childrearing practices – skills needed in the bureaucratic milieu. By contrast, in families of entrepreneurial fathers (characterized by risk-taking, competition, insecurity about the future), the mothers emphasized individual achievement and striving. One gets the clear sense that the father's work milieu provides clues to families about the qualities to encourage in their children, a phenomenon that occurs even in nonindustrial hunting and gathering societies.

Research by Melvin Kohn and his colleagues shows that men in working-class jobs stress obedience and conformity in their childrearing values while middle-class fathers prize self-direction and independence.[5] It should be noted that childrearing *values* are not the same as the activities and actual behaviors that a father carries out in socializing his children. These studies tell us that the work men do is important and related to the values they hold, but they do not tell us how these fathers behave or how their children develop. With few exceptions, the developmental outcomes of school performance and social adjustment, for example, which were emphasized in the research on working mothers, have not been pursued in research on men, because men have been

Photo: Library of Congress

seen as providers first, fathers second.

A notable exception is Glen Elder's research on the impact of the Depression on the development of two samples of children from working-class and middle-class backgrounds, one group born in the early 1920s, the other in the late 1920s.[6] Using data collected over a 40-year period, Elder compared children whose families were deprived as a result of the economic disaster with children from the same backgrounds whose families were not deprived.

The results were not only dramatic but consistent with other studies mentioned above. For youngsters who were teenagers during the Depression years, economic deprivation often had a salutary effect on their development, especially in middle-class families. These young people did better in school, were more likely to go to college, achieve more in their subsequent careers, and had happier marriages than their peers from nondeprived families. What appears to be the key to this striking pattern is that the teenagers from the deprived families were needed to help put their families back on their feet. Their part-time jobs and family responsibilities made a crucial difference in the families' welfare and provided the teenagers with early lessons in initiative, responsibility and cooperation.

Children who were of preschool age during the Depression fared less well, particularly boys. In the deprived

Photo: Paul Conklin

"Mothers took on added responsibility and status during the lean years."

Photo: Michael D. Sullivan

"There is growing evidence that having a mother who works outside the home can be beneficial for girls."

families, the boys did less well in school, had less successful work histories, and exhibited more emotional difficulties than the boys in the nondeprived families. A young boy in a deprived family would probably have had an unemployed father whose loss of status in the family and unhappiness would have been a weak model for a son too young to contribute to the family economy himself. Young daughters, on the other hand, did not experience such troubles, probably because their mothers took on added responsibility and status during the lean years, providing examples of competence to their daughters.

Elder's study provides not only a developmental history of the children, but also a dynamic picture of family life. A shift in a father's work status produces shifts in a mother's work situation and family status, as well as in the children's role in the family economy. Elder's study highlights the importance of examining the interrelationship between work and family, as opposed to examining mothers' and fathers' employment separately.

The trend today is toward dual-earner families. Moreover, demographic studies suggest that this trend will continue throughout the 1980s. We should therefore concentrate less on the parents' work status per se and more on their coping strategies—the ways they choose to coordinate work and family life. What activities are taking place in dual-earner homes? How is housework managed? What childrearing styles are mothers and fathers using? What are children contributing to the family economy? How is child care selected? Which coping strategies are the most beneficial to children? The answer probably will be "It depends." And rightly so.

In the 1980s, two community institutions outside the family will ultimately enhance or impede children's development: child care and the workplace itself. The United States lags behind most other industrialized countries in the provision of quality child care, including both the care of young children and, as is too often overlooked, the supervision of school-aged children and adolescents. The implications this neglect has on the American family is telegraphed in the title of a recent book by Sheila Kamerman, *Parenting in an Unresponsive Society* (Free Press, 1980). High-quality child care must be made available to 2-career families, and particularly to single parents, who often have no other adult on whom to rely for help and support.

Likewise, work organizations can become more sensitive to the needs of parents, a policy that might well pay off in terms of a stable, satisfied work force and enhanced productivity. Some examples of employer-based family supports already in existence in scattered work sites around the country are maternity and paternity leaves, flexible scheduling, job sharing, sick leave for parents whose children are ill, flexible or "cafeteria" employee benefits, and work-site child care. In addition, employers can and should monitor the impact work policies and practices have on families in the hope of accentuating those activities that support families while minimizing practices that exert needless stress and pressure on them. In so doing, employers will be making a long-term investment in the next generation of employees—mothers, fathers and citizens.

What will happen if society does *not* make that long-term investment? What will happen to children? Again, it depends. It depends how ingenious young families' coping strategies are, their ability to find satisfactory child care arrangements, and their ability to weather periods of unemployment and lay-off during hard times. For some children, this will not be enough. ■

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[1]U. Bronfenbrenner and A.C. Crouter, "Work and Family through Time and Space," paper prepared for the National Academy of Sciences' panel on work, family and community, Washington, D.C., 1982.

[2]L.W. Hoffman, "The Effects of Maternal Employment on the Academic Attitudes and Performance of School-Aged Children," paper prepared for the National Institute of Education, 1980.

[3]E. Maccoby, "Effects upon Children of Their Mothers' Outside Employment," in *Work in the Lives of Married Women*, proceedings of a conference sponsored by the National Manpower Council, Columbia University Press, 1958.

[4]D.R. Miller and G.E. Swanson, *The Changing American Parent: A Study in the Detroit Area*, John Wiley and Sons, 1958.

[5]Melvin L. Kohn, *Class and Conformity: A Study in Values*, Dorsey Press, 1969.

[6]G.H. Elder, Jr., *Children of the Great Depression*, University of Chicago Press, 1974.

NEWS & REPORTS

Getting Involved

The Head Start Bureau, ACYF, under contract with CRC Education and Human Development, Inc., a subsidiary of Contract Research Corporation, has produced an annotated bibliography and a series of parent-directed monographs for the Basic Educational Skills (BES) projects.

The 144-page bibliography is intended to serve as a resource guide for administrators, staff and parents in planning and working with children at school and at home. Most of the entries focus on children of preschool age and in kindergarten and first grade. As the BES Program continues, the bibliography will be expanded to include information about children through the sixth grade level, their parents and their teachers.

The bibliography is organized into four major sections: curriculum, parent involvement, teacher attitudes and behaviors and continuity. These are further divided into smaller subsections which focus on particular issues or subject matter.

Getting Involved: Basic Educational Skills Bibliography (Stock number 017-092-00083-9) is available, at $5.00 a copy, from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

The nine parent-oriented booklets, which have been developed under the general title of "Getting Involved," provide ideas and suggestions for parents to help children acquire developmentally appropriate basic skills. Individual areas covered include not only language, writing, science, reading and math, but also such conceptual ones as a child's attitude toward learning, children and television, problem solving and play. The illustrated booklets are also available, together or singly, from the U.S. Government Printing Office—see inside back cover of this issue for prices and ordering information.

Some Good News

Infant mortality in the United States decreased from 12.5 deaths per 1,000 live births for the 12 months ending with January 1981 to 11.6 for the 12 months ending with January 1982, according to provisional data released by the National Center for Health Statistics. The figures reflect a 6-percent decrease in the rate for infants under 28 days old and a 7-percent decrease in the rate for infants aged 28 days to 11 months.

The estimated death rate for infants under 28 days old decreased from 8.3 to 7.8 deaths per 1,000 live births. For infants aged 28 days to 11 months, the estimated rate decreased from 4.1 to 3.8 deaths per 1,000 live births.

Other figures released show a marriage rate of 10.6 per 1,000 population for the 12-month period ending with February 1982. The divorce rate for the 12 months ending with February 1982 was 5.3 per 1,000 population, up 2 percent over the 12-month period ending with February 1981.

The birth rate for the 12-month period ending February 1982 was 15.8 live births per 1,000 population, one percent below the rate recorded a year earlier. The fertility rate for the same 12-month period was 67.3 live births per 1,000 women 15-44 years, also about one percent below the rate for the 12-month period ending a year earlier.

The figures appear in the *Monthly Vital Statistics Report*, Vol. 31, No. 2, DHHS Pub. No. (PHS) 82-1120, available free from the National Center for Health Statistics, Room 157, 3700 East-West Highway, Hyattsville, Md. 20782.

Aspirin Warning

The Committee on Infectious Diseases of the American Academy of Pediatrics (AAP) has concluded that salicylates, such as aspirin, probably contribute to Reye Syndrome and advised that aspirin not usually be given to children with suspected cases of chicken pox or influenza.

In a special report in the June issue of *Pediatrics*, the AAP journal, the Committee, which questioned whether any fever control medications should be given when symptoms of either chicken pox or influenza are present, recommended alternatives—increasing the child's fluid intake and sponging with tepid water—when physicians believe a child's fever must be controlled.

Similar recommendations were issued last February by the Centers for Disease Control (CDC), based on an expert panel's review of studies conducted in Arizona, Michigan and Ohio. The studies indicated a statistical, but not necessarily a cause and effect, relationship between the use of aspirin for children's viral infections and Reye Syndrome.

Although both the AAP committee and the CDC panel conceded that their recommendation was made without absolute proof of causality, they concluded that the present evidence of aspirin association with Reye Syndrome is too strong to be ignored.

Because some portions of the scientific community question the data from the studies, the AAP has suggested to the National Academy of Sciences that a review of the aspirin-Reye Syndrome association be conducted.

The AAP committee urged government agencies to undertake "appropriate review and necessary action to inform the public at large," and noted that physicians and pharmacists can contribute to the effort by counseling parents regarding the potential hazards.

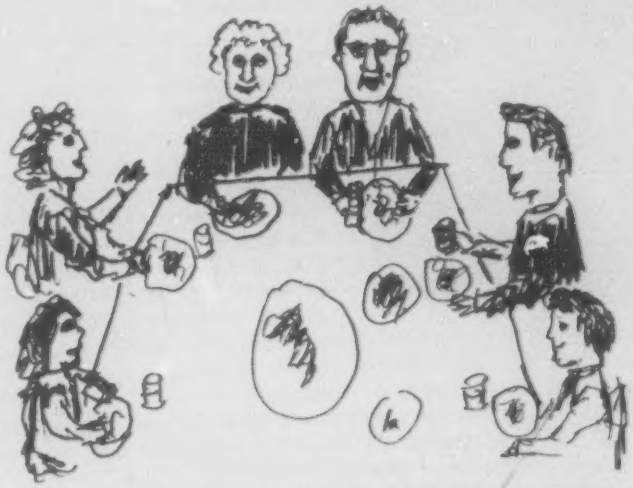
CDC estimates that 600 to 1,200 cases of Reye Syndrome occur each year in the United States, mostly affecting children between the ages of five and 14, and that death results in 20 to 30 percent of the cases, and permanent brain damage in many others.

Between Generations

"Aging Together: Intergenerational Relationships" was the theme of the first Commissioner's Forum, sponsored by the Administration on Aging (AoA) in Washington, D.C., last May as part of Older Americans Month observances.

About one-third of all persons over the age of 65 have at least one great-grandchild, Lennie-Marie Tolliver, AoA Commissioner, told forum participants and it was the quality—satisfying or unsatisfying—of relationships between the older and the young generations, and how these relationships affect individual members of each group, that formed much of the content of the forum discussion. Addressing the meeting were three invited speakers: Arthur Kornhaber, M.D., a psychiatrist and coauthor with Kenneth L. Woodward of *Grandparents/Grandchildren: The Vital Connection* (Anchor Press/Doubleday, 1981); Michael Novak, author and resident scholar in religion and public policy at the American Enterprise Institute, who spoke on the role of the family in providing economic and social supports to older members; and Carol Tice, an educator and consultant on intergenerational programs, who recounted some of her experiences in bringing the generations together.

Where have all the grandparents gone? Dr. Kornhaber and Woodward ask in their book and Kornhaber's talk, like the book, discussed the results of interviews he and his wife Carol conducted with grandparents and grandchildren (some from the same families) in an effort to learn their feelings about the strengths or lacks in their relationships. The Kornhabers visited more than 300 youngsters, who ranged in age from five to 18 years. They asked them to draw pictures of their grandparents and they listened to their comments on them. They talked with some of the children in their homes and with some in schools, churches and community centers.



Deborah showed her grandparents presiding over Sunday dinner.

The Kornhabers also met with 300 grandparents—in their home towns, in retirement communities and in nursing homes. Each of them was asked to respond to a formal questionnaire, which often was used as the core of an interview.

"Active, functioning grandparents are scarce," Dr. Kornhaber told forum attendees. "We found a very age-segregated society. Ours is becoming a society of surrogates—surrogate families, surrogate parents and surrogate grandparents. Of the children we visited, 80 percent reflected the life situation of most American children, who have only sporadic visits with their grandparents.

"Mobility is not the main cause of this distancing," Dr. Kornhaber asserted. Rather, it is a state of "disconnection." "The majority of grandparents. . .," he explains in his book, "were to varying degrees disconnected from their grandchildren," a situation which occurs, he says, when any one or a combination of the four following factors "crucial to maintaining vital connections" are missing: time, place, commitment to family and personal altruism.

"Mental health professionals," he said, "haven't helped the situation for the caring and concern so often associated with traditional grandparent roles are now often

(Children's drawings from "Grandparents/Grandmothers: The Vital Connection.")

K.I.D.S. Fund

With royalties from the sale of the *Judy Blume Diary* (Dell Publishing Co.), the author of popular books for young people has established a small charitable organization to provide modest grants—averaging $2,000 to $3,000—to community organizations for special projects and programs to enhance parent-child communications.

The K.I.D.S.—Knowledge, Independence, Decision-Making and Sensitivity—fund is accepting applications from non-profit organizations for projects that foster and reward these values in young people and that lead to increased mutual awareness and respect between parents and children. A total of $30,000 will be awarded during the grant year, which runs between September and June.

Applications will be reviewed beginning September 1. A letter of inquiry, stating the type of project and size of grant required, should be sent prior to submitting a proposal, to Mary Pinto, Director, K.I.D.S. Fund, 54 Riverside Dr., New York, N.Y. 10024.

viewed as 'meddling.'"

Summarizing the study of grandparents' views in his book is this disturbing sentence: "In visiting some 300 American grandparents we found that only 15 of them were intimately involved with their grandchildren. Another 15 or so were totally detached from their grandchildren's lives. The majority, therefore, were intermittently involved with their grandchildren and this, we conclude, is the dominant pattern in American families."

How important grandparents can be to children is perhaps best seen in the children's drawings, Dr. Kornhaber says. He showed forum participants a selection of them (50 children's drawings are included in his book), illustrating the reactions of three different groups of children: those who have close contact with their grandparents and who portray them as "large, active, fully-viewed figures. . .indicating their intimate [and happy] knowledge of them"; those who have sporadic contact with grandparents and whose drawings of them show "themes of abandonment and detachment"; and those children who have minimum or no contact with grandparents, who draw "distorted, bizarre or unrealistic images. . ."

Gail drew her nurturing grandmother "holding the baby over her heart."

Elizabeth said that her grandmother "turned her back" on her when Elizabeth's parents were divorced.

In the concluding chapters of their book, Kornhaber and Woodward present an "Agenda for Grandparents," a call to "halt the segregation of young from old and resume their natural function as foundation of the family."

The proceedings of the May forum will be available later this year.

Instructional Materials

Two new resources will be of special interest to educators in a variety of settings and to parents and teachers of children with handicaps:

WINC Curriculum. Curriculum materials to help young women overcome sex-role stereotyping as they explore careers have been developed by the Women in Nontraditional Careers (WINC) Project at the Northwest Regional Educational Laboratory in cooperation with the Portland (Ore.) Public Schools. The project is funded by the Women's Bureau, U.S. Department of Labor.

Although designed for use in public high schools, the materials are also appropriate for use in service agencies, private industry training programs, community colleges and women's academic studies programs.

The 9-unit WINC course includes a 609-page curriculum guide ($29.50 each); a 62-page journal ($4.00 each) in which young women record their feelings about the changing role of women in relation to their own career planning; and a set of 18 black-and-white, 14" x 17" posters ($20.00/set).

The complete curriculum may be ordered for $53.50, or materials may be purchased separately, from the Office of Marketing, Northwest Regional Educational Laboratory, 300 S.W. Sixth Ave., Portland, Ore. 97204.

Special Education Catalog. A free catalog of 116 special education products, including instructional materials for children, assessment instruments, equipment items and training materials suitable for use

by parents, teachers, special educators and other practitioners working with handicapped children, is available from LINC Resources, Inc., in Columbus, Ohio. The commercial publication and distribution of the products are arranged by LINC, under a contract with the Special Education Programs (SEP) of the U.S. Department of Education.

The catalog, according to Victor Fuchs, director of the Market Linkage Project for Special Education under LINC resources, is a convenient tool "to make the job of selecting special education materials a little easier." Fuchs points out that the detailed indexes help users to locate materials by subject, curriculum area, disability or education level, and objective descriptions help in deciding which materials really match the users' needs."

Single copies of the *Special Education Materials* catalog are available from LINC Resources, Inc., 1875 Morse Road, Ste. 225-C, Columbus, Ohio 43229.

Battered Women

Under the Rule of Thumb, a report issued by the U.S. Commission on Civil Rights, evaluates the treatment of battered women by the criminal and civil justice systems and social service agencies.

According to the report, police officers, prosecutors and judges too often treat spouse abuse as a private family matter rather than a crime. It points out that while shelters for battered women are needed to provide temporary safety and support so that victims can begin to use the criminal justice system, certain police practices and informal procedures—such as counseling and mediation—tend to screen out spouse abuse cases. "Such informal settings tend to produce an atmosphere of fear and coercion for abuse victims, frequently result in no criminal action against defendants and minimize any implication of wrongdoing by abusers," the Commission found.

In its recommendations, the report states that police officers responding to domestic violence calls should take whatever action would be appropriate were assailant and victim not related or acquainted—while bearing in mind the extra protection necessary for victims who may be emotionally or financially dependent on their assailants.

The Commission also urges prosecutors to give battered women the same protection, support and respect given other victims of violent crime. It calls for judges to impose sanctions in spouse abuse cases commensurate with the seriousness of the offenses and comparable to those imposed in cases where the parties are not related.

A second Commission report, *Federal Response to Battered Women*, describes the federal resources available to state and local groups and reviews 19 major federal programs (in effect during 1979-80) that show how agencies can respond to the needs of battered women. It also contains the Commission's findings and recommendations on the use of federal programs to address domestic violence.

Single copies of both publications may be obtained free from the U.S. Commission on Civil Rights, Publications Warehouse, 621 N. Payne St., Alexandria, Va. 22314.

On Women

An overview of research on the health and development of women is reported in *Women: A Developmental Perspective*, the proceedings of a 1980 NIH conference sponsored by the National Institute of Child Health and Human Development (NICHD); the National Institute on Aging and the National Institute of Mental Health.

Writing in the foreword, Norman Kretchmer, M.D., Ph.D., who was director of NICHD at the time of the conference, notes that the institutes "joined forces to explore, along a developmental continuum, a broad spectrum of research questions relating to women—from events occurring prior to birth, through earliest growth and development, into adolescence and maturity."

The 36 participants, who represented a broad range of disciplines within the biomedical, behavioral and social sciences, included Estelle R. Ramey, Ph.D., of Georgetown University Medical School; E. Mavis Hetherington, Ph.D., of the University of Virginia; the late Jeanne H. Block, Ph.D., of the University of California Institute of Human Development; Mary S. Calderone, M.D., of the Sex Information and Education Council of the United States; Ross D. Parke, Ph.D., of the University of Illinois; and Gloria E. Sarto, M.D., Ph.D., of Northwestern University Medical School.

The 411-page conference report, edited by Phyllis W. Berman, Ph.D., of the NICHD Center for Research for Mothers and Children, and Estelle Ramey, is divided into seven sections: Women's Health Concerns, Infancy to Womanhood, Women and Work, Reproduction and Giving Birth, Women and the Family, Sexuality and Middle and Later Years. Extensive references, tables and charts are included.

Single copies of the report (NIH Pub. No. 82-2298) are available free from NICHD, Office of Research Reporting, Bldg. 31, Rm. 2A32, Bethesda, MD 20205.

Restitution—An Alternative

A new organization, the National Juvenile Restitution Association, has been formed to promote an alternative—restitution—to incarceration for convicted youthful offenders.

"Not only does restitution pro-

vide a decent, practical and cost-effective alternative to incarceration," says Michael Katz, president of the non-profit association, "but it stresses accountability of the youthful offender, offers redress to long-neglected victims and builds community confidence in the juvenile justice system."

The association, which is based in Reno, Nevada, was formed last fall by a group of juvenile restitution project directors and others committed to building on the experience and knowledge gained from a major federal initiative.

In 1978, the Federal Office of Juvenile Justice and Delinquency Prevention (OJJDP) allocated more than $30,000,000 to develop research and demonstration projects relating to the impact of the restitution concept on the juvenile offender, the victim, the juvenile justice system and the community at large. Subsequently, the OJJDP awarded 41 grants to local and state jurisdictions for both individual and statewide projects. Some of the projects were court-operated; others were operated by private organizations or state agencies. The goal was not only to test restitution as an alternative but also to test various means of structuring and administering such projects. Although the final national evaluation of the program is still being conducted, preliminary results showed restitution to be an effective form of sanction in the juvenile justice system.

The aims of the National Juvenile Restitution Association (NJRA) are to share the information already gained on effective restitution programs; to provide technical assistance and training to courts and juvenile justice practitioners in developing and implementing such programs; and to enhance public understanding and support of them.

The NJRA will develop standards for planning and operating juvenile restitution programs and it will assist policymakers and agencies in developing approaches based on a philosophy of accountability at every stage in the judicial proceedings.

A workshop on restitution projects will be held in September under the joint sponsorship of the National Council of Juvenile and Family Court Judges and the NJRA.

More information and a brochure on the NJRA may be obtained by writing to the National Juvenile Restitution Association, P.O. Box 8000, University of Nevada, Reno, Nevada 89507.

Chicken Pox Complications

Chicken pox, caused by the varicella virus, is, for most children, a relatively harmless disease. For those whose immune systems are suppressed, however, chicken pox can be a severe, complicated and sometimes fatal disease. A severe case, if untreated, may involve spreading viral infection to the lungs, liver and brain.

Children with leukemia, whose disease is treated with anti-cancer drugs or radiation that suppress the immune system, are particularly vulnerable.

The National Institute of Allergy and Infectious Diseases (NIAID) reports that in one study of 77 children with cancer who developed chicken pox, seven percent died of the virus infection. Most of the children had leukemia. Ann Arvin, M.D., assistant professor of pediatrics at Stanford University Medical Center, found that more than 30 percent of children undergoing anti-cancer therapy who contract chicken pox may sustain life-threatening spread of the disease—often leading to pneumonia or hepititis—and as many as seven percent may die.

Dr. Arvin notes that currently, the only treatment related to chicken pox is an immune globulin that can be injected shortly after a person is exposed to the virus. However, researchers are investigating—in separate studies—the effectiveness of a vaccine given to children with cancer who might be exposed to chicken pox, and the use of interferon to treat chicken pox in young cancer patients.

In a study supported by NIAID at 27 medical facilities, 500 children (under age 15) with leukemia will receive a varicella vaccine developed in Japan and used effectively there to protect high risk children. The purpose of the NIAID study is to confirm and extend the results of the Japanese study.

None of the children in the study have had chicken pox, and they have no antibodies to the varicella-zoster virus in their blood. (The latent virus can cause zoster, or shingles, in later years; zoster is also occasionally seen in childhood following chicken pox in patients whose immune systems are suppressed.)

Only children who might be exposed to chicken pox through a household contact are eligible for the study, and each child must have a sibling or parent who also has not had chicken pox and who also is negative for the varicella-zoster antibodies.

According to NIAID, statistical averages indicate that of the 500 children vaccinated, approximately 20 will be exposed to chicken pox in their households in the two years following vaccination. Without vaccination 90 percent of those—18 children—would be expected to develop chicken pox after exposure. Investigators expect to determine the effectiveness of the vaccine by comparing this probability of infection with the number of children who actually develop chicken pox in the two years following vaccination.

Principal investigator of the NIAID-supported study is Anne A. Gershon, M.D., associate professor of pediatrics at New York University School of Medicine.

In a study published in *The New England Journal of Medicine* (April 1, 1982), Dr. Arvin and associates report on the effectiveness of interferon in reducing the complications of chicken pox in children with cancer. The study was conducted at Stanford's Children's Hospital, St. Jude Children's Cancer Research Hospital in Memphis, and by physicians in the Children's Cancer

Study Group, a national group supported by the National Cancer Institute that aims to standardize treatment of childhood malignancies.

In 44 children with varying types of cancer who also came down with chicken pox, interferon therapy was administered to 23 while a harmless placebo was given to 21. Some of the children received higher doses of interferon than others.

After seven days, 90 percent of the children who received interferon had been free of new rashes and spread of disease for at least a day, as compared with 56 percent of the children who received placebos. Among children who received higher doses, after six days 92 percent showed no new evidence of spread of disease for at least a day, as compared with 45 percent of those who received placebos. Overall, the incidence of "fatal and life-threatening varicella was 8.7 percent (two of 23) in the interferon group and 28.6 percent (six of 21) in the placebo group," the researchers reported.

"Our study showed that intramuscular interferon could be safely administered to immunocompromised patients with varicella (chicken pox) on an outpatient basis," the researchers stated. "With the availability of large quantities of interferon from new sources, its use for the treatment of varicella and herpes zoster in high risk patients has become practical."

The researchers are continuing to investigate interferon therapy in children with cancer. However, before interferon could be used routinely to treat chicken pox, its side effects must be carefully monitored, Arvin pointed out. Even if the side effects are minimal, its use would best be restricted to those likely to have serious complications. And thus far, she said, there is no way of predicting, except in immune-weakened patients, who is in this high risk group.

BOOKS

Successful Adoption: A Guide To Finding a Child and Raising a Family
Jacqueline Hornor Plumez, New York, Harmony Books, 1982, 234 pp., $14.95.

Reviewed by Elaine J. Schwartz

Information and guidance to those interested in adoption are offered by the author, a psychologist in private practice in New York City. She presents an overview of the various types of adoption programs, including adoption of children with special needs, intercountry adoption and agency and independent adoption of healthy young children, and she discusses how one goes about assessing which type to choose. Different agency approaches are described, from that of the Edna Gladney Home, which provides maternity care for unmarried mothers and infant adoption services, to those of Tressler-Lutheran Social Services, which specializes in finding adoptive families for children with special needs, and Homes for Black Children in Detroit, which places black children of all ages.

Plumez offers abbreviated short courses on how to tell a child about adoption, the search for birth families, how to respond to neighbors' questions and how to handle some of the problems that may come with adoption. She also discusses the future of adoption and how the system is changing or needs to be changed.

The several appendices are useful and diverse; they provide lists of public agencies in each state, agencies for foreign adoption, state-by-state facts on adoption and other information of interest to prospective adoptive families. Easy to read, the book will be helpful to those just starting to think about adoption and it can be used by agency staff members as a resource and referral book for prospective adoptive families.

Elaine J. Schwartz is adoption specialist, Children's Bureau, ACYF.

Day Care: Scientific and Social Policy Issues
Edited by Edward F. Zigler and Edmund W. Gordon, Boston, Auburn House Publishing Co., 1982, 515 pp., $24.95 (cloth), $12.95 (soft cover).

Reviewed by Edith H. Grotberg

This remarkable book makes innumerable contributions to scientific and social policy issues surrounding day care. It clarifies where we are in considering day care, what knowledge and values guide us in addressing it and what options are available for present and future programs and policies. It includes a solid review of research in the field, a careful examination of public policy, an unusual synthesis of research and policy and a reasonable set of options to address the continuing and growing interest in and need for day care.

Twelve chapters (Part I) are devoted to the review of research. The focus here is not limited, as it so often is, to parent-child bonding and early day care experiences: the chapters in Part I present information from a variety of studies and analyses that examine how personality characteristics of young children, parental skills and the personal and material resources of the staff influence a child's early day care experiences. The research reviewed also dis-

tinguishes the differential effects of day care experiences among children from different socio-economic backgrounds. Most of the research on day care has, in fact, been conducted with children from low-income families, and the tendency has been to generalize findings from these studies to the entire population. The section on research here avoids such generalizations and sets clear limits to the interpretation of findings.

The research data presented on quality and costs in day care, its long-term impact, parent involvement, children's responsiveness to adults and environmental differences in day care centers all contribute to understanding the complexity of the day care experience. Nevertheless, none of the contributors to these first 12 chapters avoids the issue of applying findings to programs. Each is prepared to say, in effect, "With the knowledge we have to date, we are willing to make these recommendations for application to day care programs."

The last 10 chapters of the book (Part III) are focused on social policy issues, including the politics of day care standards, the case for public support of day care and a careful analysis of what is presently feasible in day care social policy. Indeed, some clear-cut policy options are provided, including suggestions for federal, state and local cooperation, suggestions for using and building on current tax benefits and social service programs, and expanding the information and referral concept into networks of service provision.

This section goes well beyond day care, however, extending into the home and community environments in which children live. Consistently expressed is the view that day care should be considered together with the health, nutritional, economic, housing and special services needs of the children and their families. The argument for the broader contextual perspective is made especially for children at risk because of economic conditions, minority status, handicapping conditions or family status. It is this broader perspective that tends to polarize supporters of day care.

Some of the differences are presented in chapters 13 and 14—Part II—written by two United States Senators, Orrin G. Hatch and Edward M. Kennedy. While the two senators are assumed to be at opposite ends of the political spectrum on day care, they are in agreement on a number of issues. Both emphasize the importance of the family in all things pertaining to children. Both recognize that families need help from society and that parents carry increasingly oppressive burdens trying to raise children when jobs are scarce, when both parents work or when only one parent is present in the family.

The senators' differences mainly concern the role of the federal government.

Each of the book's editors, psychologists Edward F. Zigler and Edmund W. Gordon, has a long-standing commitment to scientific and social policy issues relating to day care. Zigler, director of the Bush Center and of Child Development and Social Policy at Yale University, was the first director of the Office of Child Development (now ACYF). Gordon, also at Yale, is editor of the *American Journal of Orthopsychiatry* and was instrumental in developing this book under the auspices of the American Orthopsychiatric Association.

The group of authors they were able to bring together attests to their stature: Sally Provence, Richard R. Ruopp, Bryon Egeland, Anne Robertson and Victoria Seitz—to name only a few of the contributors—are not only first-rate researchers but they are at the cutting edge of research questions important to day care. Policy experts such as Rochelle Bush, James A. Levine, Evelyn Moore, Julius B. Richmond and Juel M. Janis—again, not an exhaustive list—bring research findings into critical policy issues and, even more important, go beyond the present status of research and policy to suggest new directions.

Another notable dimension of the effort is the role of the Bush Foundation, which has been supporting work that combines research with policy analysis. The results of such support have been to help both researchers and policymakers understand the inherent joining of their efforts. Research can be conducted, as appropriate, with policy decisions in mind and policy can be developed drawing on available research data. *Day Care* is a major testimony to the benefits of Bush Foundation support.

Edith H. Grotberg, Ph.D., is special assistant to the Associate Commissioner for Developmental Services, Administration for Children, Youth and Families, OHDS.

Guidelines to Decision-Making in Child Welfare

Sister Mary Paul Janchell, The Human Services Workshops, 12 West 12th Street, New York, N.Y. 10011, 1981, 93 pp., $2.00.

Reviewed by Cecelia Sudia

This handbook on case assessment, service planning and appropriateness in service selection was developed by the author under a contract from the New York State Department of Social Services. It describes an approach to assessment that provides a basis for decision making in regard to the use of services or resources to prevent the need for out-of-home placement, and a guide to appropriate placement when that is necessary. While the experience background and treatment environment is the New York City system, we believe that any worker or supervisor is likely to benefit from reading this clear and economical exposition.

The discussion on preventive services is limited to about 10

pages, with no discussion of intensive in-home family therapy. There is also no discussion of case management beyond stressing its importance.

Given the paucity of materials of this kind, the current volume is valuable in spite of the limitations noted. It might have been more useful, however, if the format had included some of the "decision tree" materials developed in permanent planning handbooks.

Readings in Public Policy

Edited by John C. Hull, Donna Martin Hamparian, John M. Pettibone and Joseph L. White, from the series, Major Issues in Juvenile Justice Information Problems, Columbus, Ohio, 1981, 517 pp., $12.00.

Reviewed by Cecelia Sudia

This excellent policy reader was produced with funds from the Office of Juvenile Justice and Delinquency Prevention (OJJDP) of the Department of Justice. The entire first section deals with the issues and problems involved in the interstate placement of children, whether for child welfare, mental health treatment or other reasons.

The nine authors stress that abuses in the child welfare, mental health and educational systems are multiplied when interstate placement occurs. Further, the remedies offered by licensing or through interstate compacts are clearly unable to control the abuses. A number of recommendations for improving the situation are made.

Additional sections deal with youth in adult courts and juvenile court services. This is an excellent and up-to-date policy resource.

Cecelia Sudia is Family Services Specialist, Children's Bureau, ACYF.

How Does It Feel To Be Old?

Norma Farber, illustrated by Trina Schart Hyman, Creative Arts Book Co., 833 Bancroft Way, Berkeley, Calif. 94710, 1981, unpaged, $3.95, paper.

Reviewed by Judith Reed

An honest attempt to portray some of the pleasurable as well as inevitably limiting aspects of old age, the book is written in the first person, as told to a companionable granddaughter. "How does it feel to be old?" the narrator asks in a series of free verse monologs. Answer: "Very nice. I don't have to listen to parents' advice." And "Quite brave, quite bold!/say what I choose—/having nothing to lose." Then another answer: "In a rush!/So much to be done, so few/more years in which to do. . ." And again: "Quite late./ There's somewhere I'm getting to, soon./I haven't been told."

The drawings which appear on each page are equally thoughtful strong and imaginative.

Grandma's Wheelchair

Lorraine Henriod, pictures by Christa Chevalier, Chicago, Albert Whitman & Co., 1982, unpaged, $7.50.

Reviewed by Judith Reed

Four-year-old Thomas watches his older brother go off to kindergarten each morning and then he runs down the sidewalk to grandmother's house for *his* morning activities. She is confined to a wheelchair and Thomas helps her with the household chores and enjoys being hugged, read to and praised in turn. This is a cheerful ("Level One Concept Book") for young children, who can learn that age and handicap are not barriers to affection, accomplishment—and fun.

Cover illustration by Christa Chevalier for "Grandma's Wheelchair."

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GETTING INVOLVED: YOUR CHILD AND PROBLEM SOLVING. HHS, OHDS, ACYF, Head Start Bureau. Pub. No. (OHDS) 81-31146. 1981. 20 pp. $2.25 (GPO Stock No. 017-092-00085-2).

GETTING INVOLVED: YOUR CHILD AND READING. HHS, OHDS, ACYF, Head Start Bureau. Pub. No. (OHDS) 81-31148. 1981. 20 pp. $2.25 (GPO Stock No. 017-092-00086-3).

GETTING INVOLVED: YOUR CHILD AND SCIENCE. HHS, OHDS, ACYF, Head Start Bureau. Pub. No. (OHDS) 81-31143. 1981. 18 pp. $2.25 (GPO Stock No. 017-092-00082-1).

GETTING INVOLVED: YOUR CHILD AND TV. HHS, OHDS, ACYF, Head Start Bureau. Pub. No. (OHDS) 81-31149. 1981. 16 pp. $2.00 (GPO Stock No. 017-092-00088-0).

GETTING INVOLVED: YOUR CHILD AND WRITING. HHS, OHDS, ACYF, Head Start Bureau. Pub. No. (OHDS) 81-31147. 1981. 16 pp. $2.25 (GPO Stock No. 017-092-00080-4).

GETTING INVOLVED: YOUR CHILD'S ATTITUDE TOWARD LEARNING. HHS, OHDS, ACYF, Head Start Bureau. Pub. No. (OHDS) 81-31150. 1981. 20 pp. $2.25 (GPO Stock No. 017-092-00087-1).

GETTING INVOLVED: YOUR CHILD AND LANGUAGE. HHS, OHDS, ACYF, Head Start Bureau. Pub. No. (OHDS) 81-31145. 1981. 20 pp. $2.25 (GPO Stock No. 017-092-00089-8).

GETTING INVOLVED: YOUR CHILD AND MATH. HHS, OHDS, ACYF, Head Start Bureau. Pub. No. (OHDS) 81-31144. 1981. 20 pp. $2.25 (GPO Stock No. 017-092-00081-2).

GETTING INVOLVED: YOUR CHILD AND PLAY. HHS, OHDS, ACYF, Head Start Bureau. Pub. No. (OHDS) 81-31151. 1981. 20 pp. $2.25 (GPO Stock No. 017-092-00084-7).

GETTING INVOLVED: BASIC EDUCATIONAL SKILLS BIBLIOGRAPHY. HHS, OHDS, ACYF, Head Start Bureau. Pub. No. (OHDS) 81-31168. 1981. 144 pp. $5.00 (GPO Stock No. 017-092-00083-9).

Published by the Head Start Bureau, Administration for Children, Youth and Families, the annotated bibliography was developed to serve as a resource guide for administrators, staff and parents in planning and working with children at school and at home.

The nine parent-oriented booklets in the Getting Involved series are designed to help parents, teachers and others help children acquire developmentally appropriate skills at home and in school.

See story, News & Reports section.

PREVENTING TOOTH DECAY: A Guide for Implementing Self-Applied Fluorides in School Settings. DHHS, PHS, NIH, National Institute of Dental Research, Publication No. (NIH) 82-1196. 41 pp. Single copies free from the National Caries Program, NIDR, Westwood Bldg., Room 549, 533 Westbard Ave., Bethesda, MD 20205.

This 40-page booklet explains various steps and activities needed to start a self-applied fluoride (SAF) program in school settings (day care centers, preschool programs and K through grade 12) to prevent dental caries.

WOMEN: A DEVELOPMENTAL PERSPECTIVE. DHHS, PHS, NIH, National Institute of Child Health and Human Development. Publication No. (NIH) 82-2298. 411 pp. Single copies free from NICHD, Office of Research Reporting, Bldg. 31, Rm. 2A-32, Bethesda, MD 20205.

Presents the proceedings of a 1980 NIH conference sponsored by the National Institute of Child Health and Human Development, the National Institute on Aging and the National Institute of Mental Health to explore research questions relating to women.

See story, News & Reports section.

NINTH REPORT OF THE NATIONAL HEART, LUNG, AND BLOOD ADVISORY COUNCIL. DHHS, PHS, National Institutes of Health. Publication No. (NIH) 81-2334. 19 pp. Single copies free from the Publications Section, Office of Information, National Heart, Lung, and Blood Institute, Bethesda, MD 20205.

Recent accomplishments in the prevention and control of diseases of the heart, lungs, blood vessels and blood are described in nontechnical language.

HOSPITAL DAYS—TREATMENT WAYS: Hematology-Oncology Coloring Book. DHHS, PHS, National Institutes of Health. Publication No. (NIH) 81-2085. 28 pp. Single copies free from National Cancer Institute, Office of Cancer Communications, Bldg. 31, Rm. 10A-18, Bethesda, MD 20205.

A coloring book with explanatory captions to familiarize children—and parents—with some of the procedures a young patient may experience or see others experiencing in the hospital.

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